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ORIGINAL COMMUNICATIONS.

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Colloid Degeneration of the Skin. CHARLES J. WHITE, M.D. 49
Vegetating Dermatitis Developing During the Course of Infantile Eczema. G. W. WENDE, M.D., and H. K. DEGROAT, M.D. 58
Vaccina Generalisata. M. L. HEIDINGSFELD, M.D. 67

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JOURNAL OF
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Original Communications.

COLLOID DEGENERATION OF THE SKIN.

BY CHARLES J. WHITE, M.D.,
Assistant in Dermatology in Harvard University.

THE discovery of a new case of this extremely rare condition seems to the writer a sufficient cause to review the past literature upon the subject and to add to the meagre list of observations the results of his personal investigations.

In 1866, E. Wagner reported the first example of this affection under the title colloid milium. The patient was a woman, fifty-four years of age, whose occupation was not recorded. About six months before her appearance at the clinic the woman had had severe headaches, which had persisted for six or eight weeks. At the time of entrance she presented upon her forehead, across the bridge of her nose, and upon the cheeks above the molar prominences, many small tumors. The skin of the forehead was thickened and crossed by several furrows which retained the normal color of the skin. Between these depressions appeared many brownish yellow, glistening, small, thickly placed, but never coalescing, roundish elevations, which seemed to the eye like vesicles, but to the touch revealed themselves as firm masses. On deep pricking with the needle no fluid, save a drop of blood appeared, but on pressure between the fingers a pale yellow, glistening transparent substance exuded. On microscopical examination this expressed mass appeared as small cylindrical bundles which remained unaltered in the presence of acetic acid, alkalies, iodine and sulphuric acid, and which corresponded in other ways to the tests for colloid matter. Hence Wagner concluded that he had to do with a

colloid change which he placed in the sebaceous glands of the skin and called his unusual tumor colloid milium.

Thirteen years later Besnier recorded the second instance of this condition and with the aid of Balzer gave us a truer conception of the subject which has remained unaltered up to the present time.

In 1879, a forest warden appeared at the St. Louis Hospital. He was forty-six years of age and had apparently never noticed the peculiar condition of his skin. Upon the bridge of the nose, over the temporal and about the orbital regions of the face appeared brilliant yellowish, translucent elevations which stood out conspicuously from the brown weather-beaten skin. At first sight they resembled vesicles, but incision revealed only a droplet of blood and to the touch they proved firm and elastic. The lesions apparently were bounded by the finer lines of cleavage of the skin, and, therefore, appeared in many shapes and varied in size up to the dimension of a kernel of wheat. On curetting these tumors a slightly blood-tinged, gelatinous mass appeared which resembled colloid matter. These lesions differed from xanthomatous masses by their greater brilliancy, darker color and firmer consistency. In addition to the above conditions, Besnier noted similar appearances on the conjunctiva near the inner angle of each eye and on the septum nasi, and further elicited from his patient the fact that he had had severe, almost daily, occipital headaches.

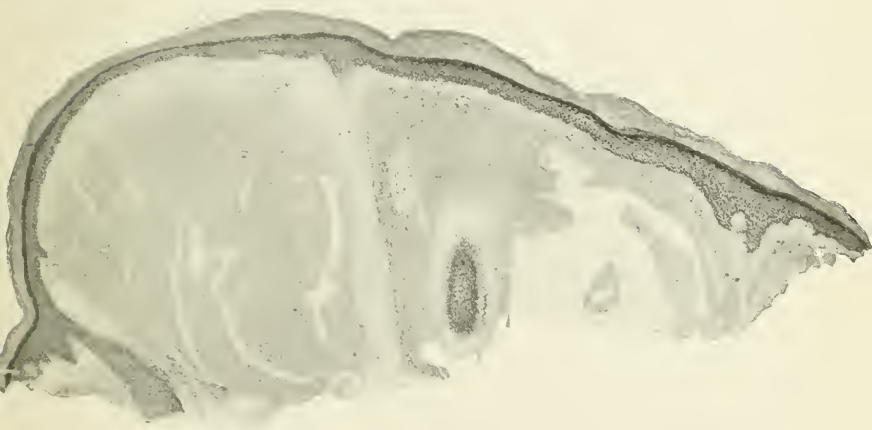
Balzer found that the expressed gelatinous mass consisted of homogeneous bundles of connective tissue which became orange yellow on staining with picrocarminate of ammonia and remained unmodified by acetic acid. He further noted that these bundles were enclosed in an amorphous envelope consisting of normal connective tissue cells.

His examination of sections stained with picrocarminate of ammonia only confirmed his first investigations. He found the epidermis thinned in all its layers, the stratum corneum very fine, the stratum lucidum invisible, and the rete cells flattened and in some places vacuolated—in other words, marked signs of presssure—and where the colloid blocks beneath were largest there the epidermis showed the most marked alterations. In the corium he found the chief seat of the disturbance where the colloid masses had completely flattened out the papillæ and pushed aside the glandular elements of the skin. Immediately below the epidermis, around the glands, and by the side of the hair follicles, Balzer could always distinguish a thin strip of connective tissue which thus separated the colloid substance from the epithelial elements of the skin which were never involved in the colloid change. The colloid masses were colored a yellowish-orange, and where the process was more marked the fibers were swollen, less undulating and

finally became homogeneous masses. The few nerve trunks visible remained unaltered, but the vessel walls, on the contrary, shared markedly in the degenerative process. The external tunic appeared hyaline, brilliant, thickened and in places bosselated, while the intima was thickened, but not degenerated. These alterations were proved not to be amyloid. As these vascular changes were noted at some distance from the colloid blocks, Balzer concluded that the whole disease was due to primary involvement of the blood vessels.

From these anatomical data Besnier was able to locate the true

FIG. 1.



Section stained with hematoxylin-eosin. Corium practically reduced to a homogeneous mass devoid of usual elements. Lacunæ are artificial, due to shrinkage.

seat of the degeneration in the corium and to demonstrate the fact that the sebaceous glands played no part in the process. Therefore, colloid milium was a misnomer and Besnier rechristened the disease colloid degeneration of the corium—the title which dermatologists employ to-day.

In 1885, Feulard discovered the third example of the disease in a gardener aged forty years, who had always been exposed to the open air. The disease had first appeared seven years before as two small yellow elevations on the left cheek. In eighteen months the whole

right cheek and the nose were covered with similar lesions and four years later the forehead and the left ear were invaded. At the time of his visit, Feulard noted small, lemon-yellow, transparent elevations varying in size up to the dimensions of a millet seed. These yielded on excision and firm pressure a jelly-like substance tinged with blood. In addition to the cutaneous lesions Feulard found yellow lines running transversely across the cornea.

Balzer studied this series of tumors also and found conditions exactly similar to those noted in Besnier's case. In addition he treated some sections with eosin and 40 per cent. hydrate of potash, and claimed that he could demonstrate the integrity of the elastic fibers around the colloid blocks. He again asserted the prominent etiological rôle of the blood vessels.

One year later, in 1886, Liveing published a communication upon this same subject and claimed, without microscopical examinations, that he had met with three new examples of colloid degeneration of the skin. The tumors resembled xanthoma, but were bright and translucent.

His first case was a young woman. His second a man, whose tumors appeared on the face and neck, and at the end of a year the disease had run its course and the lesions had disappeared. His third example was in a girl of sixteen, on whose face, neck and arms he observed similar elevations, many of which grew soft and depressed in the center, became later inflamed and covered by a crust and finally disappeared, leaving behind them slight depressions in the skin. The better preserved lesions appeared as small, slightly elevated, yellowish, flattened, translucent projections of semi-solid nature, surrounded in many cases by vessels.

On account of the age of the patients, the seat of the tumors and their subsequent life history, it does not seem proper to the writer to accept these cases, especially without histological proof, as genuine examples of colloid degeneration of the skin.

In 1890 Philippson wrote an article in which he put forth an unusual claim. A syphilitic woman of twenty-five consulted him about her disease and during his examination Philippson discovered upon her lower eyelids two hemispherical, millet-seed-sized nodules, smooth on the surface, tense to the touch and imbedded in the cutis propria. These nodules were of the same hue as the surrounding normal skin, were more transparent than the ordinary milium, and had existed as long as the patient could remember.

In a second patient, aged thirty-nine, Philippson observed a few similar lesions upon the eyelids and several others upon the chest, one

of which he examined microscopically and found to be an example of hydradenoma of Darier (syringo cyst adenoma, Török), benign cystic epithelioma (Besnier, etc.), with subseqent colloid changes. As the result of this examination Philippson inferred that after all both Wagner and Besnier were in error and that the disease under discussion

Fig. 2.

Weigert's elastic tissue stain. Darker regions are degenerated elastic tissue (elacin): The central, lighter portion is colloid mass.

was not colloid milium or colloid degeneration of the corium, but was indeed hydradenoma, followed by colloid changes.

This sweeping inference seems quite untenable to me on clinical and on histological grounds.

At the second international dermatological congress in Vienna, in 1892, Perrin described the fourth undoubted instance of colloid degeneration of the corium. The patient was a woman rag-picker of fifty-four years, who had spent her mornings in collecting rags and

her afternoons in sorting them, always sitting in full sunlight near the sea.

Scattered over her forehead, bridge of nose, temples, upper part of cheeks and backs of hands appeared yellowish, translucent, firm, roundish elevations, pin-head in size, which often existed in great numbers, but never coalesced. These stood forth conspicuously from the brown, weather-beaten, thickened skin. In addition Perrin noted on the conjunctiva, at the inner angle of each eye, yellow, lobulated, movable masses.

The histological investigations of Reboul were most complete and detailed. Reboul found that all the layers of the epidermis were thinned. The stratum corneum consisted of a very fine layer, the cells of the stratum granulosum were vesicular in places and much reduced in number, and the stratum mucosum was practically absent in certain areas. The corium consisted of blocks of colloid matter of various shapes and sizes, stained yellow orange by picro-carmine and surrounded by pink staining connective tissue. The larger areas were bounded by excretory sweat canals and by hair follicles, but he always noted the delicate intervening band of pink-staining connective tissue which separated the degenerated homogeneous connective tissue bundles from the epidermal structures which completely enclosed them. Where the transition from normal to degenerated tissue was most sharply marked, embryonal and connective tissue cells were abundant and normal.

A new feature observed on the outskirts of these sections was a granulo-fatty change which Reboul considered might be the possible forerunner of the later process. In the hypoderm the connective tissue was condensed into a thick layer where a few vessels appeared with degenerated middle and outer coats. The glands were normal, but their surrounding connective tissue envelope was slightly affected by colloid changes. In closing his remarks, Reboul emphatically states that he cannot agree with Philippson's conclusions.

The last publication upon this subject which has come to the writer's notice was by G. H. Fox, who observed in a coachman, aged thirty-two, a disease which Fox said resembled at first glance acne or syphilis. In the labio-nasal fold, on the chin between the eyebrows and on the upper border of the ear appeared nodules varying in size from a pin's head to a split pea. The lesions were firm, flat, dull red to yellow red in color with some umbilication. The larger ones were softer and yielded blood and pus on incision and on pressure produced a crackling sound, as though one were in the presence of a multilocular cyst. Other tumors gave out a gelatinous material with considerable hemorrhage.

Elliot reported on microscopical examination that the tissue suggested very strongly tuberculosis. Some of the tumors were curetted and others left to themselves. The latter all disappeared during the following summer, leaving a pock-marked look to the skin.

This case also seems to the writer, from its clinical and histological characters and its later changes, not to belong to true colloid degeneration. Thus from the whole of the literature we are enabled to report only four unquestionable examples of this most unusual condition.

Before adding what we consider to be the fifth undoubted case yet recorded, let us make a few quotations from Unna, who was enabled to examine with his specific stains some of the sections from Perrin's case. He found that the fainter stains of elastic tissue noted by Perrin (Reboul) were due to the presence of elacin, and that the colloid blocks were surrounded, as Balzer had stated, by a shell of elastic tissue which had broken down into drops, fragments and small granules, and that even around the smaller colloid blocks, elastic tissue still persisted. He then states that the collagen (normal fibrous tissue) progressively breaks up and combines with elastin (normal elastic tissue) to form collastin (staining in orcein-water, blue, brown-red with orcein, while the normal collagen absorbs the blue tint). Later a further combination of collagen with elacin (basophilic elastic tissue) ensues and produces collacin (which absorbs basophilic colors and appears as small granules within degenerated collagenous bundles). Unna remarks that he has never before noted collacin in such abundance. Finally, by the further disintegration of the collagen the connective becomes the homogeneous mass known as colloid.

The elastic tissue also undergoes changes and becomes elacin, but there the process stops and this tissue never reaches the colloid state.

Our example of colloid degeneration occurred in an Irishman, aged fifty-two, who had never lost a day's work on account of illness, but had suffered for the last ten years from recurrent attacks of hay-fever. From boyhood up to the age of thirty-two the patient had been a gardener in Ireland. He then came to America and pursued the occupation of a hod-carrier for ten years, and finally, ten years ago, received the position of gate tender on one of our steam railways. Thus we have a long life during which the man had been constantly exposed to the effects of the hot sun of summer and the cold winds of winter.

Four years ago the first lesions were noticed upon the back of one hand and during the following two years many similar nodules developed on the exposed parts of the body and have persisted until the present time. The man complains of no subjective symptoms and came

to the Massachusetts General Hospital solely on account of the abnormal condition of his skin.

The individual lesion is a smooth, flat papule from ⅛ to ¼ of an inch in diameter, irregularly rounded or polygonal in outlines, exceedingly translucent and yellowish brown in color, and soft, elastic, and almost gelatinous to the touch. The papules project perhaps ⅛ of an inch above the surface and present a very unusual appearance. They are situated on the backs of the hands, radiate in an acute angle from the outer canthus of each eye, occur in lesser numbers upon the cheek and entirely cover the whole surface of the tragus, antitragus and pinna of each ear, giving the latter a notched look when seen in profile.

On the alæ of the nose there are groups of large black comedones and here and there are yellow concretions, polygonal in shape, filling up the mouths of the follicles. The nose, as a whole, is rather increased in size.

A nodule was excised from the back of the hand, hardened in alcohol and imbedded in celloidin for examination.

Epidermis.—The stratum corneum is distinctly hyperplastic—markedly so over the follicular openings—and the many anuclear cells are thrown up into well-separated lamellæ. The stratum lucidum is also more pronounced than usual. The stratum granulosum consists, for the most part, of three to four layers of cells, but over the central portion of the underlying tumor mass it recedes to one or two layers and the individual cells become especially less granular and appear flattened and elongated. The stratum spinosum is also diminished in depth—the germinate layer being apparently quite wanting, and in its place we find many flattened vacuolated cells, while above we note the disappearance of many nuclei. Mitoses and pigment are totally absent. Thus the epidermis presents the typical appearances resulting from pressure.

Corium.—Looking at the sections with a low power we see two masses of tissue quite uniform in structure, intersected in three places by hair follicles. In some of the sections one of the masses has fallen out, leaving only the follicular boundaries. The papillæ have entirely disappeared and in their place we find a narrow, dense zone which follows down by the side of the hair follicles on either side and unites below the tumor mass in a much thinner band. This consists, for the most part, of degenerated elastic tissue in the form of coarse, straight, irregularly swollen or broken fibers, which absorb the characteristic stain of elacin. Here and there we find a few areas of normal elastin which absorb the Weigert stain sharply and appear as small tortuous fibrillæ. This surrounding zone of elacin lies coincidently with the

only area of the corium in which we find any normal connective tissue and even here the collagen is reduced to a minimum.

Within this zone of elacin we find the tumor proper consisting of small or large irregularly shaped islands of tissue bounded at intervals by capillaries whose walls show thickened masses of elacin. (The large, dilated lacunæ which appear in the photographs are artificial and due to the contraction of the celloidin during the last year.) Within these enclosing capillary walls the true colloid material appears composed of a ground-work of fine or coarse granules which stain uniformly yellow with picric acid and a bluish green with polychrome, methyl blue and orange tannin. Scattered through this homogeneous mass one is surprised to note perfectly preserved connective tissue nuclei and on approaching the encapsulating vessels to find many surrounding leucocytes with a rare plasma cell.

In studying this degenerative process we have been disappointed in not finding any collacin or collastin which Unna found so abundant in his slides, but we feel that perhaps the reason may lie in the possibility that the degeneration had completely attained its end result and not that our technique was at fault. To test the value of specific tissue stains one should employ several methods, if posible, for the same tissue, and then compare the slides one with another. For this purpose we have used hematoxylon-eosin, which gives us a good collagen and elacin stain; Weigert's elastic stain, which colors elastin sharply and dark and elacin in a lesser degree; Unna's acid fuchsin-picric acid stain, which he considers so useful in detecting the presence of collacin and colloid matter, and, lastly, Unna's complicated method by acid orcein-polychrome methylene-blue-orange tannin, which stains elastin and collastin dark brown, elacin and collacin and nuclei blue, and collagen yellow.

VEGETATING DERMATITIS DEVELOPING DURING THE COURSE OF INFANTILE ECZEMA.

By GROVER WILLIAM WENDE, M.D., and HERMAN K. DEGROAT, M.D.,
Buffalo.

WE wish to report two cases of a rare skin condition, to be supplemented by a consideration of such other similar cases as have already been reported. Our record of the first case is imperfect, so far as the beginning of the trouble is concerned, but the mother of the child is thoroughly intelligent and what she says may be accepted. The photograph which we have taken represents the case when first seen—that of a patient who came to us in January, 1897, when he was about eight months old. The trouble began with seborrheal eczema, starting on the scalp when the child was only three weeks old and later spreading to the face. This process was active or quiescent at different times, like that of a typical eczema.

In December, 1896, the mother first noticed pustules on the scalp, which rapidly developed into quasi tumors. On January 30, 1897, when the case first came under our notice, lesions of the same character were found on the face and scalp. Most of them were nodular squamous masses, varying in size from a bean to a child's fist. The larger were made up of smaller ones which had coalesced and assumed an irregular contour. The lesions appeared rough and scaly and, on removal of the débris, a vegetating appearance was seen. Often in the border of the larger groups, as well as in their immediate vicinity, many small pustules appeared. These were also found scattered over the whole involved surface, and varied in size and stage of development. They were sometimes found in groups but were usually isolated. After removing the scales, oleate of mercury was twice applied daily. The lesions cleared up in three weeks and did not return. No scarring resulted, and their only remaining trace was a slight pigmentation.

The second case was first seen March 8, 1901, that of a child then six months old who was reported healthy at birth, nursed by her mother, and continued well until she was five weeks old when a seborrheal eczema was developed at the vertex of the scalp, which, in four months, spread over the entire scalp. When she was about four months old, and during an almost complete remission of the eczema, the lesions which were especially to interest us began to develop. At

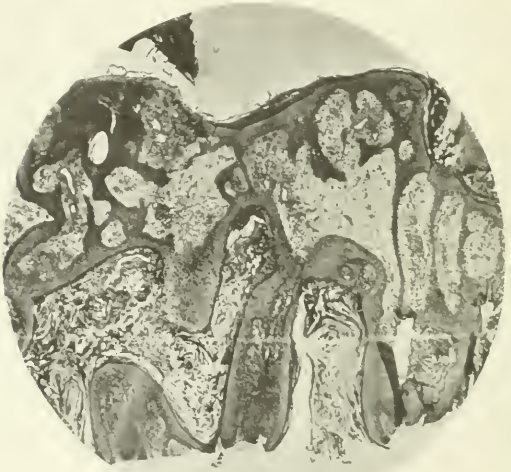
first small and few in number, they attacked the eczematous area, some appearing in groups while others were diffused. Others soon appeared, the older ones increasing in size, some becoming, in a very short time, as large as a walnut.

Fig. 1.

On examination March 8th, the child then being six months old, the scalp still showed traces of the seborrheal eczema, but none was found on other portions of the body. On the scalp there were ten well-developed lesions, varying in size from a pea to a hickory nut. These were well raised above the surrounding surface, and were covered with crusts in which matted hair was embedded. On the forehead, near the median line, were two papillomatous lesions of filbert

size, with uneven surfaces, covered with crusts, the entire mass being firm to the touch. The lesions were well defined and the surrounding surface seemed healthy. On the right cheek, on a line with the nares, was a lesion surrounded by seven small discrete pustulo-papules, varying in size from a pinhead to a large pea. The small lesions contained very little pus at their apices, their bases were reddened and raised. On the left cheek was one large lesion the size of a fifty-cent piece and one inch deep, composed of coalescent lesions: at two points a

FIG. 3.



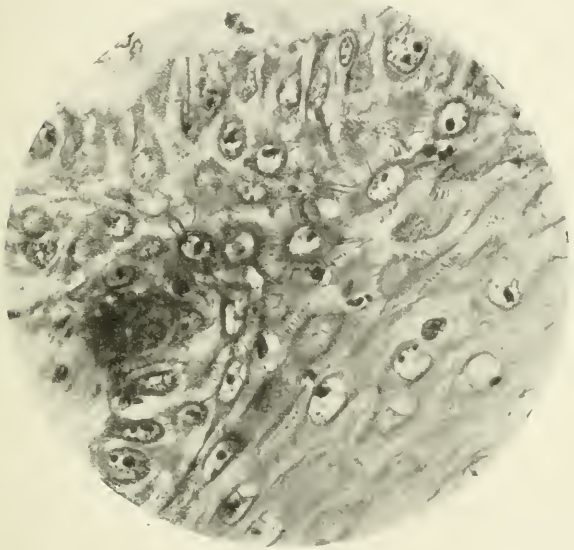
Papillomatous lesion showing hyperplasia of rete

small amount of pus could be pressed out, and the most gentle manipulation resulted in bleeding. On the left leg, over the anterior surface of the tibia in its lower third, was an incrusted lesion about the size of a silver dollar. During the lapse of two weeks, a number of minute isolated pustules appeared among those already formed. On the day following, in an effort to obtain bacteriological material, a crop of pustules appeared on the chest which showed upon examination, three days later, small isolated pustulo-papules extending over an area 3 inches wide by 5 inches long. There were about thirty

of these lesions, from a pinhead to a dime size, raised above the surface, each one of them surmounted by miliary pustules. Three of them appeared papillomatous and formed circular reddish plaques.

As to treatment, as already intimated regarding the first patient, in six weeks all evidences of the disease were removed. In the second case, the treatment was simple: crusts were removed with water pre-

FIG. 4.



Same section more highly magnified, showing well-defined prickles, with granular cell remains in the meshes.

viously softened with oil. Antiseptic ointments were applied, oleate of mercury was used on the head and sulphur upon the body. Both applications acted equally well. In eight weeks the condition had entirely disappeared, although the treatment was discontinued for two weeks in order to obtain material for bacteriolofical examination.

Bacteriological Examination.—Cover slip preparations from the miliary pustules showed plenty of staphylococcus epidermidis albus. All kinds of media were used and inoculations from the pustules, as

well as teased tissue, were made. The cultures, after twenty-four hours, showed white colonies which were almost a pure growth of diplococci, very small and were stained by Gram.

Further study, by the planting of micro-organisms on the various culture media, potato, gelatine, milk, bouillon, etc., showed almost a pure culture of the small organisms which arranged itself singly, in pairs and in small bunches. A few of the tubes contained a mixed culture. Several colonies corresponded to those found in the previous tubes. The other organism was staphylococcus pyogenes albus.

Histopathology.—Two tumors, representing different periods in growth, were removed for microscopical examination. These were placed in Zenker's fluid and alcohol and stained by various stains, including those for bacteria.

Horny layer.—The horny layer was entirely removed or became moderately thickened. The surface contained much débris, consisting of blood capsules, shreds of horny epithelium, and, in portions not detached, large nucleated epithelial cells.

Stratum lucidum.—This was not discovered in the diseased skin. There were no cells to be found distinct from the stratum granulosum although eleidin granules could be noted by means of the oil immersion.

Granular layer.—The granular layer was deepened and, in the more recent growth, increased by two or three layers; it was, however, much thinner in the older lesions. There were a number of leucocytes seen in this as well as in the horny layer.

Rete.—This layer was uniformly and excessively thickened, causing projections which dipped deeply into the cutis. Evidence of edema appeared. The superficial cells showed vesicular nuclei, although occasionally shriveled nuclei could be seen. All the cells, even the superficial ones, possessed distinct prickles. Leucocytes were found between the cells of the superficial layer and in certain places had resulted in a formation suggestive of pustules.

Cutis.—The blood and lymph vessels were specially dilated, particularly under the elongated papillæ. There was a decided infiltration of leucocytes and a few plasma cells in the papillary layer of the corium. In the deeper layer they were limited to close relation with the blood-vessels. The leucocytes were almost invariably lymphocytes. Polymorphonuclear leucocytes were present, but rarely proliferating connective-tissue cells. In the older tissue the changes were essentially the same, although many of the cells showed regressive alterations, the leucocytes, in many instances having aggregated and formed pustules. No micro-organisms were discovered.

Dr. Hartzell kindly loaned us a microscopical slide of the case, a synopsis of which forms a portion of this article. His and our cases all exhibit a benign hypertrophy; his case, however, being older, was, of course, more marked, and included well-formed miliary abscesses. In our case there were several collections of leucocytes possibly the beginning of similar ones.

With these two cases before us we may look at their common characteristics. We find in each the following lesions; first, the superficial miliary pustules from which a droplet of pus can be squeezed. These are surrounded with reddened bases varying in size. As the base increases, the pustules apparently disappear. Later, the lesion is covered with scales and crusts. At the same time the base becomes elevated above the surface of the surrounding skin and assumes a more or less circular papillomatous vegetating appearance, which is seen on removal of the crusts. These vegetations arise either from the base of a single pustule or by the coalescence of several lesions. They show a peripheral extension and form a group of pustules; the more recent ones, upon removing their crusts, appear intact at the border of the growth. The largest reach an elevation of one inch. The etiological factors are not striking. The first question is whether the dermatitis vegetans is strictly and entirely the result of eczema. This seems hardly possible, because such a complication is rarely manifested. May it not be due to a circumscribed or a secondary infection? Careful inquiry was made regarding other members of the family, but no such cutaneous malady was found to exist. We know that non-specific lesions of the skin may accompany other forms of secondary infection. The mode of development and the rapidity with which the lesions responded to antiseptic treatment suggest the possibility of some micro-organism as the inceptive influence in this affection. Further, has this condition arisen as a result of medicine taken by either mother or child? Careful inquiry led to a negative conclusion. In differentiating these cases from those more recently specified in medical literature, one would naturally think of Blastomycetic Dermatitis, especially when the microscopical appearance is taken into consideration. The benign hypertrophy and the small accumulations of leucocytes suggestive of miliary abscess formations are points in common with that disease. No blastomycetes were found in the cutis by Dr. Gilchrist, who kindly looked over the specimens and reported a negative examination. Syphilis, Pemphigus Vegetans and Dermatitis Herpetiformis were eliminated after due investigation and consideration.

Perrin, in *Annales de Dermatologie et de Syphiligraphie*, 1900,

No. 10, reports three cases of nurslings which seems to correspond with ours. Seborrheal eczema of the scalp in one case had spread to forehead and cheeks. The lesions involved none of the hairy portions of the body but were found on forehead, cheeks and chin, upon the wrists, chiefly on their dorsal surfaces, and upon the posterior and external surfaces of the thigh and legs. The primary efflorescence, as observed in these cases where new lesions developed during the course of the disease, was a pustulopapule. The pustule was miliary and was situated upon a small papule varying in size from a millet-seed to a lentil. The union of several of these pustulopapules formed a secondary lesion which is also characteristic, viz.: the papillomatous vegetation which is covered by a crust. The surface of one of these vegetating plaques was dark red. It was clearly limited, more or less circular in form, elevated above the surface and not painful to palpation. In older plaques, that is, those of over fifteen days, the center was covered by a crust, while at the periphery recent pustulopapules were present. The vegetations varied in size from a half dime to a twenty-five cent piece (20 ctms. to 2 franc) and some had a polycyclic contour. They were quite superficial and elevated one-third to one-fifth of an inch above the surrounding integument which was wholly unaffected, so that the crusts appeared to be "stuck on" to the skin, as in impetigo contagiosa. Under treatment, the vegetations disappeared leaving granulæ maculæ, which, in turn, were obliterated, leaving pigmented areas, like those following impetigo. These finally faded out and left no trace whatever. In no case did scars result. The durations of individual lesions under treatment with mild antiseptics was from two to three weeks. Perrin's observations were made upon infants 2½, 4½ and 7 months old. All these were apparently healthy at birth—the mothers were the same. The babes were nursed by the mothers, were fat and seemed vigorous, had no gastroenteritis and were in perfect health when examined, except for the seborrheal eczema which was present in each case, as were the peculiar lesions which concern the present inquiry. No medicines had been taken by either mothers or infants which might account for the lesions, particularly no bromide. The theory of syphilis was also excluded.

A comparison of these cases with our own shows many points of resemblance. All the cases occurred in nurslings afflicted with seborrheal eczema but otherwise in good health. The lesions seemed similar in the papulopustules of the primary efflorescence, in the secondary changes, in size, in appearing in crops, in development, in disappearance, in duration, and in the readiness with which they yielded to

treatment. There was no recurrence in any of the cases. The real differences seem trifling. In none of Perrin's cass did the lesions appear upon the scalp, which was the original seat of the seborrhea, while in both of our cases the scalp was involved. Further, we found that the vegetations would bleed readily when handled. Perrin makes no note of this. The points of resemblance are so numerous and the differences so slight that we feel justified in considering our cases as manifestations of the same condition existing in those reported by him.

A short summary of anomalous cases appearing in adults, but presenting features similar to those characterizing the cases which we have reported, will be of interest. In 1894, Hallopeau, in *Annals de Dermatologic et de Syphiligraphic,* reported a case of seborrheal eczema of eighteen months' duration occurring in a patient fifty years old. The face, thorax, axillæ and inguinal regions were involved in the seborrheal implication. A large vegetating patch similar to those already described was found upon the scalp. This yielded to mild antiseptic compresses. Although occurring in an adult, the case resembles those previously mentioned, in the manner of developing, in the presence of seborrhea, in the nature of the vegetating lesions on the scalp and in response to treatment.

Another case was reported by Hartzell in the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, October, 1901, in which the clinical appearances were strikingly like those in Hallopeau's case. It is the case of a patient 57 years old, in which lesions began with pea-sized pustules on the buttocks and scrotum, later becoming confluent and crusted and then extending to the groins and thighs. Vegetations slowly appeared, increasing in size for some months, then remaining stationary. Only occasional miliary pustules were formed, and these were in the inguinal plaques. There were no bullæ and no involvement of the mucous membranes. To quote from Dr. Hartzell's description, the plaques were violaceous in color, elevated several millimeters above the surrounding healthy skin, sharply defined in outline, and covered with a thin, whitish scale, with a few bright red oozing points scattered here and there over the surface. There was also chronic eczema of the thighs and legs. The history obtained from the patient was not clear, owing to his mental dulness. After having been under observation only three or four weeks he died from pneumonia. No appreciable changes in the lesions occurred while he was in the hospital. The vegetating lesions and the miliary pustules in this case seem like those already considered, save that they did not show so rapid a tendency to resolution.

At different times, Hallopeau has reported five cases which he collected into one report, in 1898, under the title of Pyodermite Vegetante and published the article in *Archiv für Dermatologie und Syphilis,* but he does not mention in this series the case formerly reported by him under the name of Vegetating Eczema, which possesses striking features of resemblance to the class of cases he reported as Pyodermite Vegetante. The essential lesions as described by this author consist of miliary pustules, which soon become surrounded by a reddened area or base. These pustules appear in groups, soon coalesce, burst open and discharge the pus. They then become covered with crusts, which, on removal, show reddened surfaces of a papillomatous vegetating appearance, more or less elevated above the surface of the surrounding skin. Disseminated throughout the vegetating surface on plaques, in particular studding its periphery, are found the characteristic pustules already described from which small drops of pus can be forced by pressure. The patches, or groups, of pustules increase in size by eccentric extension, and the subsequently overlying crusts and vegetating plaques show a peripheral growth. Owing to the weaker resistance of the epithelium in the mouth and on other mucous membranes, the pustules open more quickly and small ulcers result. Following the discharge of pus and the accumulation of débris, vegetations develop on the sites of these ulcers. The same appearance of the pustules in patches occurs on the mucous membranes that is so characteristic when seen on the integument. The mucous membranes of the mouth and lips, the scalp, axillæ, genitals and perigenital region, buttocks and back are the most frequent sites of the vegetating lesions. The duration of the disease, so far as mentioned, was ten to fifteen months.

The skin lesions are amenable to local treatment with weak antiseptics and find permanent cure, leaving behind only dark, slowly-fading spots and showing no distinctive tendencies. Douchings, irrigations, local applications and inunctions with boric acid, carbolic acid and camphor naphthol were used. The lesions upon the mucous membranes yield much more slowly, owing to the greater liability to autoinfection due to the moisture and the many unavoidable points of contact, as well as the impossibility of making continuous applications of antiseptics. The prognosis, with these five cases before us is quite satisfactory. There is no mention of an accompanying eczema in this series of cases.

We have now placed before you twelve cases of vegetating dermatitis, five cases being found in infants and seven in adults, with eczema invariably present in those of the children and twice in the adult series.

In both series we note the same papulopustules and vegetations. The development of the vegetating plaques and their resolution, so far as observed, seems to be similar. The appearance of the lesions in crops, with resolution of the older as the new ones appear, are also common characteristics. The lesions of the integument are quite amenable to antiseptic treatment and the prognosis as to recovery from the affection is favorable. This manifestation is more likely to become chronic in adults and is said to have a tendency to recur. In most of the adults, the mucous membranes and genitals, or peri-genitals, were involved, while in the nurslings no lesions were found in these locations. We do not know what relation this condition bears to seborrhea or eczema, as, in many of these cases, its vegetating condition was developed independent of both, but we are inclined to the opinion that the condition was due to an infection of some kind and had nothing to do with the disease.

In concluding this paper we desire to express our thanks to Dr. Gaylord, to whose skill the accompaying microphotographs are due.

VACCINA GENERALISATA, WITH REPORT OF A CASE.*

By M. L. Heidingsfeld, M.D.,
Cincinnati.

VACCINA generalisata, or as its name implies generalized, in contradistinction to localized, vaccination is one of the most infrequent form of dermatoses encountered. Chauveau states that it occurs but six to eight times in 500,000 to 600,000 vaccinations. Bondesen reports three out of 170,596 vaccinations from the government records of Denmark. Its infrequency may also be accounted for in a measure by the readiness with which slight cases may be ignored, and by the ease by which the affection may be confounded with such dermatological affections as variola, impetigo contagiosa, impetigo contagiosa bullosa, pemphigus, etc. For these and other reasons, notably the elucidation of some of the obscure features of the disease, I wish to report the following interesting case, with the kind permission of Dr. Ravogli, in whose practice I saw the case, during his recent absence in Europe.

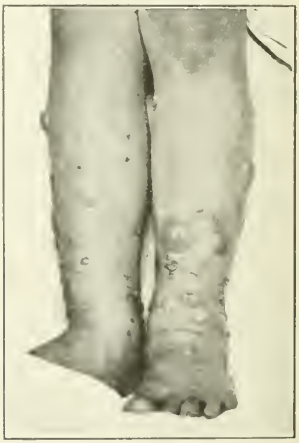
M. M., girl, aged 5 years, was vaccinated April 10th, 1901, together

* Presented before the Cincinnati Society for Original Research, Oct. 17, 1901. by Dr. M. L. Heidingsfeld, Cincinnati.

with M. P., aged 2 years. Both vaccinations were successful, and pursued a regular uneventful course. On May 2d, M. M. was brought to my notice with a bullous eruption over both ankles and wrists; the bullæ were numerous over these areas, varying from a split pea and smaller, to an English walnut and larger, in size—arising from an uninflamed base and were filled with clear serum. They were sensitive to pressure and distressed the patient, who manifested slight pyrexia, anorexia and general malaise. The eruption first manifested itself the preceding day, in the form of minute vesicles, without apparent sub-

FIG. 1.

FIG. 2.



jective symptoms; at that time the vaccination pustule had already healed, the scab had fallen away, leaving a slightly reddened, pigmented, depressed and cicatrized area—evidences of a successful and completed vaccination. On the following morning the larger bullæ of the preceding day had spontaneously ruptured, the split-pea vesicles had assumed the size of pigeon eggs, and a crop of minute vesicles appeared in the intervening normal areas and for a considerable distance further up the extremities. On this day photographs (plates 1 and 2) were taken and blood examination made. This process repeated itself from day to day, vesicles of one day assuming the size of

large bullæ the next, rupturing on the third or fourth day, leaving a denuded exfoliated reddened surface, which in the course of a week or ten days healed with slight pigmentation, and without cicatrization.

The eruption gradually extended up the extremities, and later involved the trunk, face, and scalp, leaving no surface uninvolved, and prolonging its attack over an interval of three months. Mucous membranes were uninvolved. Child had no previous dermatological affection and no pruritus in any form.

During this period emaciation and cachexia were marked, and slight pyrexia 99° to 100° was constant. Child has since made a complete recovery, appearance is good, weight normal, and skin is as clear and healthy looking as prior to the attack.

The nature and cause of the eruptions accompanying vaccination are very obscure, and in the effort to establish their true character, some clever investigation, and interesting observations have been recorded. At present, opinion is nearly equally divided as to whether they are caused by auto-intoxication, or by auto-inoculation.

That the eruption bears at least an indirect if not a direct relation with vaccina is conclusively proven by the interesting investigations of Jeanselme[1], who successfully inoculated cows with vaccina by means of the contents of the vesicles, and produced successful vaccinations in individuals by means of the virus from the udders of the inoculated animals. In the light of these facts, the intimate relation of these eruptions and vaccination cannot be questioned more than the relation of smallpox to vaccination.

As already stated, opinion is divided in regard to the *modus operandi* of the cause. Some maintain that it is the result of an auto-inoculation, that is to say, that the vaccine virus is disseminated to various points over the body corresponding to the respective sites of the later manifestations, by means of the patients' finger nails, garments, towels, sponges, and etc. Patients previously affected with some pruriginous dermatosis, are therefore predisposed by reason of incessant scratching, and the presence of abrasions. This opinion is substantiated by the fact that quite a few of the cases have been associated with the previous existence of some pruriginous dermatosis, entirely too frequently, I believe, for a matter of mere coincidence, in light of the low percentage of frequency of both conditions. There are some who maintain that this is a mere coincidence (Haslund[2]), and point out that if it were not, vaccina would be a much more common affection than it is. They ignore what I regard as a very important factor in the causation, a marked idiosyncrasy, in addition, on the

part of the patient. In our case a predisposing preëxisting pruriginous disease was absent, as also in some of the cases reported in the literature. (Darling,[3] Haslund,[4] and Gaucher.[5])

Those who maintain that auto-inoculation is the cause, claim that areas that are protected and inaccessible to the fingers (interscapular), remain free, and that the vaccination pustules invariably show excoriations. These observations do not apply to our case, nor to some of the cases reported in the literature. (Haslund,[6] Lederman.[7])

A strong point in favor of the inoculation theory is the fact that the lesions frequently but not invariably take on the characteristic appearance of the vaccination pustule, pursue a similar course, and disappear with cicatrization, often slight, sometimes very extensive, features that were not marked in our particular case.

A strong point against the inoculation theory, at least in selected cases, is the relatively short period of time until vaccination immunity is established, and often the long duration of the affection. Immunity is established in the horse on the fifth day (Chauveau[8]); in man immunity is believed to be established during the second week, though successful revaccinations have been performed as late as the twelfth and fourteenth days. It is absurd, however, to maintain that successful revaccination can be protracted over a period of three to four months, as must have been true in our particular case, if the affection is to be invariably explained on the basis of auto-inoculation. (Wetterer.[9])

Some of the cases must be accorded a different interpretation. This interpretation I take to be an intoxication in the form of misdirected vaccine virus, through the lymph or blood circulation, or the expression of reaction on the part of the patient, against intoxication from a probably intense virus, analogous to the roseola in syphilis and exanthemata of the acute infectious diseases. That misdirected virus may play the rôle in at least selected cases is evidenced by the beautiful experiments of Chauveau,[10] who found that in horses, the most susceptible of all animals, if vaccine virus is administered through the respiratory or gastro-intestinal tracts, or subcutaneously, a vaccina generalisata invariably appears, not earlier, however, than the eighth day. If a cutaneous inoculation (*i. e.*, vaccination) is previously or synchronously performed, the eruption is precluded because immunity is established not later than the fifth day. If, however, the cutaneous inoculation (vaccination) is excised not later than twenty-four hours, the eruption, vaccina generalisata, appears fifteen to twenty days later. From this it can be inferred, in man, that if vaccine virus gains access to the lymph or blood circulation, it may induce vaccina generalisata up to the time immunity is established. (Widowitz.[11]) It is inadequate to

explain cases of unusually long duration, and the eruptions in those cases are probably best interpreted on the basis of the reaction of the system against intoxication, analogous to that of the infectious diseases. The general malaise, pyrexia and emaciation would complete the picture. The occurrence of the eruption in successive crops is not, as has been claimed, a counterindication; rather the reverse, for both syphilis and herpes zoster, true types of infectious diseases, are characterized by the same condition.

In conclusion, therefore, I believe that there is good reason to believe that in a given case any of the above attributed causes can be the factor, and that those authorities who maintain that one given cause to the exclusion of all others (Wetterer,[12] Haslund,[13] etc.), is responsible for these eruptions are in error. In all probability there are two separate types of eruption, one due to direct innoculation, or misdirected virus, of shorter duration, persisting until vaccination immunity establishes itself, and characterized by lesions of the type of the vaccine pustule; and another the result of systemic intoxication, of variable duration, with lesions atypical to the vaccine pustule both as regard course and appearance. Both require a special idiosyncrasy on the part of the patient, and have nothing in common with localized complications, like erysipelas, eczema, etc.

I regret that inoculation experiments with the contents of the vesicles, on man or animals, were not attempted in our particular case. However, I cannot concur with Paul,[14] who believes that those cases must necessarily be confirmed by inoculation experiments, in order to possess significant value. The bullous character of the eruption, its recurrence in successive crops, its coincidence with a successful vaccination, its typical course, the absence of drug taking and other predisposing causes, its distinct non-resemblance to other forms of dermatoses, and its occurrence in an individual previously and subsequently free from any form of dermatoses, is sufficient evidence to render the diagnosis relatively easy and absolute, and confirmatory evidence, in the nature of an inoculation experiment, is comparatively as essential as the discovery of tubercle bacilli in a case of lupus.

With the hope that the blood examination could shed some additional light on the nature and etiology of this condition, Dr. Alfred Friedländer has been requested to kindly submit his report. I will not endeavor to interpret the interesting changes he reports, but merely wish to assert that the low eosinophilia removes the affection from the various other forms of bullous eruptions, pemphigus, etc., characterized by high eosinphilia. The blood changes noted would class the affection among the infectious diseases. It will be a matter of

considerable interest to note the blood examinations of these cases, a feature which, to my knowledge, has thus far been much neglected. It will be particularly interesting to note any variation in the cases, ascribable to auto-inoculation and to auto-intoxication, and whether or not the cases ascribable to auto-inoculation are commensurate with the examinations of the blood in vaccination, varying as they should only as regards degree.

It is greatly to be regretted that the prejudices of the parents would not allow a complete blood examination to be made in this case. It was impossible to do more than obtain smears, but even these show certain interesting features. Examination of stained specimens shows that a leucocytosis doubtless existed, which can be estimated as being about 20.000 whites to the c.m.m.

Of 675 whites counted there were:

Small lymphocytes	170	equals	25.18 per cent.
Large lymphocytes	33	"	4.88 "
Polymorphonuclears	436	"	64.59 "
Eosinophiles	36	"	5.33 "

No myelocytes were found. Only one nucleated red (a normoblast) was found in three specimens.

There was a moderate poikilocytosis, but the red cells did not show the characteristics of a marked anemia.

The low eosinophilia is striking, and is in distinct contrast to the condition usually observed in the various skin diseases with bullous eruptions. Thus the percentage is much lower than that usually found in pemphigus, which this eruption simulated so strikingly. The blood count differs also from that usually seen in variola, for the polymorphonuclears were not diminished as they usually are in that affection. The proportion of polymorphonuclears (64 per cent.) is certainly higher than the normal in a child of five, where we could expect to find lymphocytes and polymorphonuclears in about equal proportion. It is possible that this condition may be explained on the theory of infection advanced by Dr. Heidingsfeld.

BIBLIOGRAPHY.

1. *Gaz. hebd. de. med. et. chir.*
2. *Arch. für Derm. u. Syph.*, 48.
3. *Brit. Med. Jour.*, 1890.
4. *Op. cit.*
5. "Annal de Syph.," 1890.
6. *Op. cit.*, 1891.

7. *Arch. f. Derm. u. Syph.*, 27.
8. Nocard and Leclanche "Pathogenie," p. 439.
9. *Derm. Zeitschrift.*, 1898.
10. *Op. cit.*
11. *Wien. klin. Woch.*, 1896, report of a case, due to infection through the lymph circulation, the eruption appearing on the fourth day.
12 and 13. *Op. cit.*
14. *Archiv f. Derm. u. Syph.*, 1900.

Book Reviews.

Photographic Atlas of Diseases of the Skin.—By George Henry Fox, M.D. Philadelphia: J. B. Lippincott Co. 1901-2. Parts I. to VII. inclusive.

One can hardly convey any idea by description of the beauty of the plates in this atlas. The title is somewhat misleading for, while the pictures are photographic reproductions, they are tinted in a style which places them in a class with the Hôpital St. Louis Atlas and "La Pratique Dermatologique." In fact, the work seems to be a publication, within the reach of modest means, of the author's edition de luxe, which in this line is incomparable. Dr. Fox has often said that the trouble with skin photographs is that they are taken of the patient and not the disease. The contention is certainly borne out by the success of his efforts. The reader fairly itches with a desire to prick the bullæ in the pemphigus case. The selection of subjects is also generally good; the exceptions it is possible to take are perhaps only differences of opinion where an author's should prevail. The average is five plates to each part.

The reviewer's task is always a hard and generally a distasteful one, but candor compels the statement that this unqualified praise cannot be bestowed on the text. Preceding the plates in each part there is in alphabetical order a consideration of the more important affections at some length while the page opposite each picture is filled with a short article on it. Statements in the two do not always agree as when comedo is held in one place to be composed of inspissated sebum and in the other, correctly, to be a follicular keratosis. Etiology, so far as specific causation goes, receives no mention whatever. Careful search has failed to reveal the presence of a single microörganism in the text. General causes are detailed at length, however.

The author indulges in his introduction in a philippic on the subject of latter day overdosing and says that a trainer in athletics can cure a psoriasis as well as he. Doubtless he scarcely expects to be taken at his word, for under the head of its treatment, old friends, arsenic, tar and chrysarobin, are much in evidence. Middle ground as usual is the only safe one. Doubtless, also, he does not rely on the curette and hygiene alone in acne, although he claims they are enough.

After all, these things are of little account, flaws easy to pick, not faults, but there is a wilful error which will have to be unlearned by the student into whose hands the atlas falls. Dr. Fox's colleagues in the American Dermato-

logical Association have before now inquired whence he derived his right to revert to pre-Hebraic days and destroy the fruits of fifty years of labor in the classification and unification of cutaneous disease. One would imagine that treatment and prognosis alone, on which great stress is laid here, would prevent an attempt to merge seborrheic dermatitis, pityriasis rosea, "lichen ruber" and a string of other equally unrelated affections into a generic pityriasis, on the ground solely that they are scaly. Pityriasis is the title attached to an exquisite picture of seborrheic dermatitis or eczema (both titles have been shown by modern investigation to be quite correct). This is unfortunate, for the plates are quite good enough to convey accurate ideas of the beginnings of dermatology.

J. C. J.

Progressive Medicine.—Edited by HOBART AMORY HARE, M.D., and H. R. M. LANDIS, M.D. New York and Philadelphia: Lea Bros. & Co., September and December, 1901.

These volumes contain the reviews of the subjects of interest to this Journal's readers. Gottheil has done the section on skin and syphilis; Belfield, as before, that on genito-urinary disease. The personal note of criticism is present in both articles and adds greatly to their value. Half tones have been reintroduced into the skin section and, in view of their helpfulness, the Journal must approve their use as it did their absence last year. It may be that they are better done than in '99. Wonderful to relate, there are thirteen pages given up to syphilis, which, by the way, is announced on the back of the December number where it is not to be found. The reviews apparently improve as years go by. Certainly, their scope is much widened and their contents embraces all there is any need for the men in other lines to know of the advance in these specialties of ours which are accused not only of having a nomenclature but an armamentarium of their own.

Society Transactions.

FRENCH SOCIETY OF GENITO-URINARY SURGERY.

FIFTH SESSION.

(*Annales des Mal. d. Org. Génito-Urin., 1901, p. 1320.*)

Opening Address by Professor Guyon.

Movable Kidney, Pathogenesis and Indications for Operations.—Dr. Guillet.

The pathogenesis of movable kidney is still very obscure, due to insufficiency of anatomo-pathological and experimental facts. For the solution of this problem we have scarcely more than the data of clinical observation, which may be formulated in the four following propositions:

1. Movable kidney is a frequent anomaly.

2. This anomaly is much more frequent in women than in men.

3. The right kidney is much more frequently mobile than the left, or than the two together.

4. This affection is more frequently met with between 25 and 40 years of age.

These propositions are worthy of being retained, but they do not throw much light upon the solution of the problem of the pathogenesis of movable kidney.

There are numerous hypotheses, but they may be embraced under these principal groups according to which we may attribute the development of the anomaly, whether to an anatomical lesion of the kidney and neighboring organs, or to a physiological cause, or to a general disposition of the organism.

I. *Theories based upon an anatomical lesion of the kidney or the neighboring organs.*

These comprise:

a. Excessive elasticity of the peritoneum and abnormal elongation of the kidneys.

b. Atrophy of the perirenal adipose tissue.

c. Elongation of the renal vessels.

d. Relaxation of the abdominal walls, to which is attached the seductive theory of enteroptosis of Glénard.

e. Augmentation of the liver.

f. Dilatation of the stomach.

Not one of these theories based upon an anatomical lesion noted in certain autopsies can be applied indiscriminately to every case of nephroptosis.

II. *Theories based upon a physiological cause.*

Influence (*a*) of menstruation leading to an intermittent and repeated congestion of the kidneys.

b. Of pregnancy, which has been exaggerated, as the results of statistics prove.

c. Of the corset, which cannot be denied, but is not sufficient.

To these may be added:

d. The influence of traumatism, which acts above all as an occasional cause.

III. *Theories based upon a specific general condition, an innate insufficiency of the means of support (?) of the kidney.*

1. Theory of Tuffier, who admits a general malady, a deficiency due to the organs in general, characterized by insufficiency of the tissues. This insufficiency may exceptionally be limited to a single organ, as for instance the kidney.

2. Albarran's theory, who regards movable kidney as a veritable stigma of degeneracy. This theory would have the advantage of explaining the rôle of heredity, made by a certain number of observers; but it rests upon too scant a number of cases.

From a study of these theories it is plain that no one is applicable to all cases: there is then no one cause which can be invoked to explain the pathogenesis of this affection. To sum up: The general conditions of fixity of the kidney are those of the equilibrium of the intra-abdominal viscera; any cause which upsets this equilibrium may have a reaction upon the kidney.

From the notions acquired upon the pathogenesis of this affection it is not possible to draw precise conclusions for its therapy, and it is to the train of symptoms that the clinician should address his attention in order to make his decision. Under this aspect, movable kidney may be placed in one of three categories:

1. Those which give rise to no functional disturbance.

2. Those which are the seat of change more or less grave, as neoplasm, hydronephrosis, pyelonephrosis, etc.

3. Those accompanied by pain or digestive disturbances.

According to the author it is necessary in cases of the first category not to operate, in the second the operation appropriate to the condition is called for, in the third we may have recourse to nephrorraphy for the painful cases and for those which give rise to digestive disturbance, when we have proven that these disorders are due to displacement of the kidney. Before resorting to operation we should try the efficacy of an appropriate bandage.

Movable Kidney, Pathogenesis and Indications for Operation.—DR. E. CHEVALIER.

I. PATHOGENESIS.

1. *Anatomic and Physiological Considerations.*—The right kidney descends lower than the left; the kidney occupies the renal fossa variably, according to sex; in man it is deep, pyriform, and contracted below; in woman, it is superficial, small cylindrical and open below, which permits descent of the kidney (Volkoff and Delitzine).

The means of the fixity of the kidney are multiple:

(a) *Adipose Capsule of Haller.*—This is composed of two portions: the adipose element and the fibrous sac.

The adipose element is more a cushion for movement than a means of fixity.

The fibrous sac, formed by the peri-renal fascia (the pre-renal and retro-renal fasciæ) have been studied by Luschka, Henle, Simon, Sappey, Zuckerkandl, Toldt, Delagenière, Gerota, Glantenay and Gosset.

By a transverse cut we may see the union between the two layers.

By a vertical we may see the two layers envelop the kidney and the supra-renal capsule becoming attached above to the diaphragm; while below there remains a space, the posterior layer passing down into the iliac fossa, the anterior passing on to the peritoneum after becoming changed to a fine tract below the lower pole of the kidney.

Some fine fibers unite the superior pole of the kidney with the supra-renal capsule (the reno-supra-renal ligament of Glénard).

The posterior fascia, the retro-renal, is the fascia of Zuckerkandl; the anterior, the pre-renal, doubles with the layer of Toldt, which is almost always wanting on the right side and on the left kidney is formed at the expense of the primitive mesocolon of transverse and descending colons, which form a right angle upon the left kidney, while the ascending and transverse colons form an obtuse angle at the level of the right kidney.

The capsule of Haller is a rather frail support of the kidney, and can only support a traction of 2 kilog. (Troquart.)

(b) *Peritoneum.*—The peritoneum passes in front of the kidney without forming a meso-nephron, the annexing ligaments of the peritoneum attach the kidney to movable organs, those not fixed, and are really a drag upon the kidney.

(c) *The vascular pedicle* prevents displacement outward and in displacements downward causes the kidney to sway: it is more firmly held on the left where the capsular vein empties into the renal vein, which sustains moreover the reno-azygolumbar canal of Lejars.

(d) *The suprarenal capsule* contributes to the fixity of the kidney.

(e) The liver, colon, duodenum, spleen and the pancreas hold an important relation by their proper action upon the kidney.

(f) *Intra-abdominal Equilibrium.*—Volkoff and Delitzine have shown that this equilibrium results from the construction of three concentric cavities. One, external contractile (external abdominal sphincter), formed by the abdominal wall (this is the most important): a middle one formed by the parietal peritoneum; an internal contractile, one formed by the intestinal tube (internal abdominal sphincter).

(g) *Normal Mobility of the Kidney.*—The kidney conforms to the respiratory movements, descending on inspiration and ascending on expiration; it tends to descend in the vertical position and ascend in dorsal decubitus. This normal movement is greater in the feminine sex, even in infancy (Rosenthal).

II. PATHOLOGICAL ANATOMY.—The surrounding fat, sometimes rarefied or having disappeared, is often found very abundant in nephropexies; the peritoneum is very variable, sometimes in folds, often normal, never forming a true meso-nephron; the vascular pedicle elongates, especially the artery; it presents anomalies sometimes; the ureter is subject to the modifications which are found in intermittent hydronephrosis. The displacements of the kidney may be slight (anteversions or retroversions) or marked; three degrees are recognized: 1, where the kidney occupies a slightly lower plane, at its superior pole still beneath the ribs; 2, where the kidney is entirely below the ribs; 3, where it is floating (movable kidney of the flank, Glénard). There may be besides mobility of other organs, hepatoptosis, enteroptosis, when subject to abnormal compressions.

III. ETIOLOGY AND PATHOGENESIS PROPER OF MOVABLE KIDNEY.

A. FREQUENCY.—Movable kidney is very frequent; the proportion is 30 per cent. According to Albarron 10 per cent. to 12 per cent.

B. PREDISPOSING CAUSES.

(a) *Sex.* More frequent in females, even in infancy (Cowby); the anatomical considerations above explain this.

(b) *Age.* Sometimes seen in infancy and even in nurslings, but the great majority of cases occur between 20 and 35 years.

(c) *Right side.* Almost always it is seated on the right side and it is more

frequently in men that it is found on the left. Bruhl gives 80 per cent. of right-sided nephroptosis; Godard-Danhieux and Albarran, 85 per cent. to 90 per cent. The left side has a better support than the right (with the layer of Toldt); the right side is subject to the influence of the liver (when subjected to effort, compression from corset, etc., digestive troubles), that of coprostasis (occurring at the obtuse angle between the ascending and transverse colon, weight of the cæcum), that of enteroptosis.

(d) *Pregnancy.* Multiparæ are subject to movable kidney (three-quarters of the cases), but nulliparæ may also be affected. The effort during confinement, and flabbiness of the abdominal wall which follows it, above all in repeated pregnancies, and those rapidly following each other, are more apt to give rise to this condition.

(e) *Relaxation of the abdominal wall.* It is also seen after evacuation of ascites, of intra-abdominal collections, operation on large abdominal tumors, or in rapid emaciation.

(f) *Affections of the internal genital apparatus.* Thiriar believes that movable kidney provokes utero-ovarian congestions, while Landau and Knapp think that uterine affections provoke movable kidney.

(g) *Periodic congestions.* Becquet (1865) believed that the congestion of the menses reacted upon the kidney, making it heavy, depressing it and in the long run creating movable kidney. Trousseau adopts this theory.

(h) *Enteroptosis.* Glénard in 1885 gives the element of ptosis the preponderant rôle: that enteroptosis is the real trouble, while nephroptosis plays only a secondary rôle in the symptomatic picture of the affection; that it is enteroptosis which is to be cared for in order to cure the nephroptosis.

Mathieu, Ewald, Litters, Landau, Albarran believe that Glénard accords too great importance to enteroptosis. Godard-Danhieux, who has well studied this affection, concludes that nephroptosis and enteroptosis show well-marked differences.

(i) *Other affections of the digestive apparatus.* Herniæ of the cæcum (Tuffier), high degree of rectal prolapse (Bazy), have produced nephroptosis. Dilatation of the stomach (Bouchard, Legendre) provokes nephroptosis in giving rise to hepatic congestion; but this may be secondary to the nephroptosis, according to Bartels, Müller-Warneck, Landau.

According to Potain, colitis may produce movable kidney from diminution of the perirenal fat. Now this should rather tend to fix the kidney (*sic*).

The liver acts upon the kidney during effort, cough, digestive maladies, wearing of corsets; marked congestion of the liver, with or without icterus, gives rise to nephroptosis by pressure. The kidney may by pressure upon the biliary ducts give rise to the icterus and lithiasis. There is frequently enough coincident hepatoptosis and nephroptosis.

C. DETERMINING CAUSES.

(a) *Corset.* Cruveilhier shows that the corset too tightly laced compresses the kidney between the liver on one side and the vertebral column on the other; the kidney then escapes from its place like a prune stone compressed between the fingers.

Belting in too tightly, above all wearing too heavy skirts, act the same way (Trousseau, Peter, Glénard, Godard Danhieux and Verhoogen).

It is not necessary to exaggerate this cause, for many wear the corset too tightly laced without producing this condition, while Trekaki has seen 42 cases

of movable kidney in 100 Arab women who had never worn corsets or tight belts.

(b) *Increased size of kidney.* Congestion of the kidney may produce movable kidney; but degenerations of the kidney being able by their weight to depress the kidney, cause a depressed kidney rather than true movable kidney.

(c) *Traumatism.* A shock, or fall on the heels, on the knees, or backwards, a sudden effort, produce luxation of the kidney. The ordinary mechanical action which gives rise to movable kidney is slower and longer sustained.

D. HEREDITY; CONGENITAL; STIGMATA OF DEGENERATION.—The insufficiency of the precited causes, acting together or alone, has caused us to seek for the true explanation of nephroptosis in a congenital or hereditary predisposition. Lindner, Litters, Ewald, Ochsle, Bazy, Volkoff and Delitzine, Bouchard, Tuffier, Albarran above all, have shown the importance of taking note of this important factor.

IV. THE RELATIONS OF INTERMITTENT HYDRONEPHROSIS TO MOVABLE KIDNEY.

(a) *Strangulation of the kidney.* Explained by pulling upon the nervous plexus (Diehl), an arrest of the kidney in the subserous tissue (Roller), an acute attack of hydronephrosis (Gilewski), or an active congestion (Landau). The strangulation of the kidney is a sort of acute renal retention due to slight displacement (Albarran) or to a true descent of the kidney; this rôle of the kidney placed under tension has been well shown by Sinitzine, Guyon and Albarran.

(b) *Intermittent hydronephrosis.* The relation of intermittent hydronephrosis to movable kidney has been well shown by Landau, Newmann, Terrier and Bandouin.

Without detriment from slight attacks of congestion (Albarran) movable kidney has frequent attacks of slight retention, of which intermittent hydronephrosis is the higher degree. In falling from its position it undergoes a tension which brings the external border in advance or causes anteversion of the kidney (Potain) or anteflexion (Walther) or retroversion (Albarran).

In the extreme cases the pedicle of the kidney is stretched, and causes the kidney to take an oblique position downwards and inwards; then a transverse position; the lower extremity of the kidney looks inwards and forwards and the ureter undergoes important deviations.

The ureter may take the form of the letter S, may be twisted, may cause bending upon a vascular branch or upon the inferior horn of the kidney. In cases of long standing the upper portion may be in conjunction with the external wall of the hydronephrotic pouch, where it is joined by an orifice scarcely visible; often there is a valvular formation. Fibrous strands occur to fix the curvature to the vertebral column or they produce occlusion of the ureter, transforming an open hydronephrosis into a closed one.

According to Landau the cause of hydronephrosis is indeed movable kidney, as Krathauer has shown; Newmann, Terrier, and Bandouin admit this; the experience of Tuffier and that of Navarro would seem to coincide with this aspect, if those of Hildebrand and Hager did not appear to contradict it. Albarran and Legueu have shown that the kinking, not absolute at first, becomes so when the fibrous strands fix the ureter. Clinically we may agree that intermittent hydronephrosis really arises from movable kidney; since the cases of Guyon (1889), where nephropexy sufficed to give a cure, this opinion has been proven.

(*To be continued.*)

THE NEW YORK DERMATOLOGICAL SOCIETY.

A STATED MEETING, HELD OCTOBER 22ND, 1901.

JAMES MCFARLANE WINFIELD, M.D., *in the Chair.*

Case of Nævus Pilosus.—Presented by DR. MORROW.

The patient was a girl three and one-half years of age. The hairy growth covered the entire left half of the forehead, swept around the outer canthus of the eye and extended over the upper portion of the cheek, covering the entire malar region nearly to the nose. The hair was quite as thick and luxuriant as upon the hairy scalp.

I presented this patient simply to obtain the opinion of the members of this Society as to the most practical method of treatment. The patient was brought to me for an opinion, and has been under observation but a short time. Some surgeon had proposed operating by excision and transplantation of skin, and I was asked if such an operation was advisable or not. My impression is that it is doubtful whether an operation will materially improve the condition from a cosmetic point of view. I think that if an excision was followed by Thiersch's method of transplanting the skin, it would be very doubtful if the resulting scar would be more satisfactory to the patient than the present appearance. I also hoped that I might get an opinion from members of the Society as to the possible utility of using the X-ray apparatus in this case. I suppose there is always the possibility of a dangerous burn when the apparatus is applied to hairy tissues even when used under the greatest precautions.

DR. SAMUEL SHERWELL.—I think that a surgical operation is the best if not the only thing that can be done for this patient. I should like to show a case that I had in which the tumor was of about one half the same size, situated in the center of the cheek and which I removed with scarcely a visible scar left. I divided the skin around the edges of the tumor, undermining the edges of the skin, and placed two silver sutures right through the cheek to take off tension, about twenty smaller coaption sutures were employed. I think the result of an operation, probably two at different times, would be as successful in the case presented as in mine. I shall be glad at some future day to show this case to the Society.

DR. EDWARD B. BRONSON.—I should like to hear if any one present has had any experience with the X-ray in the treatment of such cases.

DR. SIGMUND LUSTGARTEN.—Electrolysis might bring down this growth, but it would be extremely tedious. Surgical interference with transplantation of cutis according to the Thiersch method might improve the appearance of the child considerably.

DR. CHARLES W. ALLEN.—I have operated upon smaller growths of this nature with electrolysis, and I find that it is a very efficacious operation, although tedious in so extensive a growth. The brown pigment disappears and the hair growth in so extensive a growth as well.

DR. GEORGE HENRY FOX.—I do not think that excision, or its removal in whole or in part by surgical operation, would improve it very much, for the resulting scar might be worse than the deformity itself. Electrolysis will remove the hairs and leave a smooth patch, but it would involve much work in accomplishing this result, and in this case such a procedure might be out of the ques-

tion. On the other hand, the application of caustics, if done very carefully, would remove the hair and the part made to look like a superficial burn. But, whether this would be an improvement upon the present appearance is a question difficult to answer. I think the easiest way would be to shave the part or use a depilatory; this probably would be most satisfactory to the patient. For cauterization I always like to use that which I can best control and, therefore, the point of an electrolytic needle is best. My most brilliant therapeutic result was obtained in a case of hairy and verrucous nævus, which was published in the Journal and in my Atlas. It took much time and patience, but the warty and hairy growth, which involved the nose and a greater portion of the cheek and the lower eyelid, was removed so that scarcely any scar was left; there was no contraction or deformity of the eyelid resulting. When this patient was last seen there was scarcely any scar to be noticed upon the face. I think that the same result could be obtained in this case, but it would require an infinite amount of time and patience.

Dr. Prince A. Morrow.—I presented this patient simply to obtain the opinion of the members of this Society as to the most practical method of treating the condition. The patient has been under observation but a short time, and the patient was brought to me for an opinion. Some physician had proposed operating upon the patient by excision and transplantation of skin, and I was asked if such an operation was advisable or not and, instead of giving an opinion, I said I would bring the child here and get the opinion of the members of this Society. My impression is that it is doubtful whether an operation will materially improve the condition present. I think that if an excision was done and Thiersch's method of transplanting the skin done, that it would be very doubtful if the resulting scar would be more satisfactory to the patient than the present appearance. I also hoped that I might get an opinion as to the possible utility of using the X-ray apparatus in this case. I suppose there is always the possibility of a dangerous burn when the apparatus is applied to tissue of this kind even when used under the best precautions.

A Case of Complete Alopeuia.—Shown by Dr. Edward B. Bronson.

The patient, a girl, was two years of age. The affection was stated by the mother to have followed a severe attack of measles with "inflammation of the lungs," when the child was nine months old. When born there was a good growth of hair on the head, and it remained normal until after the severe illness referred to. Shortly after that the hair began to fall out rapidly, first in isolated spots on the scalp, which extending caused complete loss of hair within two months affecting not only the scalp but also the eyebrow and lashes. At present the surface of the scalp appears absolutely hairless. There are not even lanugo hairs to be seen. The eyebrows are gone, but there are a few ciliæ to be seen, which the mother states have grown in recently.

Dr. Prince A. Morrow.—I never saw a patient so young with generalized alopecia. I should be disposed to think, in view of the fact that the hairs of the eyelids and eyebrows are growing in again, that the efforts of Nature alone might possibly produce a growth of hair. Cases of generalized alopecia occurring in adults which have existed for a long period of time in my opinion are not as a rule influenced by any treatment. I think that in any case in adults where there is no return of the hair in two or three years the hair will never return. But, in the case of a child when the nutritive processes are more active and pronounced I think there is some hope that the hair may yet grow luxuriantly.

DR. GEORGE HENRY FOX.—I have seen hair grow in children a little older than the one just presented and, I think, in this case the prognosis is hopeful.

With regard to the treatment I may say that I have photographed such cases and seen the hair grow in speedily.

I do not regard photography as a therapeutic measure, but think it may be quite as effective as some of the local applications which have been highly recommended. The cure which often follows their use is due mainly, if not wholly, to the action of time and the *vis medicatrix*. Any stimulation of the scalp that draws the blood to the part tends to favor the nutrition of the hair.

DR. CHARLES W. ALLEN.—I have seen generalized alopecia occurring in quite young children, and I some years ago presented a girl of about nine years who, up to last year, had not recovered her hair; her head is as smooth as a billiard-ball. Recently I have had several cases of the ordinary form of alopecia, and the hair is growing under the application of pure carbolic acid; but, whether carbolic would be of much benefit in this case or not, I do not know.

DR. GEORGE THOMAS JACKSON.—Regarding the question of prognosis I should say that it was very doubtful in this case, whether the hair would come in or not. I believe the prognosis is usually bad in the universal cases. I remember one girl of five or six years of age; when I first saw her the hair was all gone. Later it came back very irregularly and in tufts, and it all fell out again. I have seen the girl off and on for ten or eleven years, and have seen the hair come and go several times. In the child just before us, of course, the hair may be restored entirely, but the outlook is not good.

DR. L. DUNCAN BULKLEY.—I think better results would follow in this case of generalized alopecia from internal treatment and proper feeding. I am a firm believer in the fact that there is some nutritive change taking place which we ought to meet. Recently I have seen two cases of generalized alopecia which were regarded as hopeless; under proper feeding, good hygienic surroundings, etc., and immense doses of dialized iron, the hair appeared, first white, and then turned black. Regarding this child I should say that she will recover her hair if placed under proper treatment. This would naturally occur more readily in children than in adults, because the processes of life are more active and readily respond to treatment.

DR. ANDREW R. ROBINSON.—I believe in the parasitic theory, and in no other. I do not see that this child is suffering from malnutrition. What the prognosis will be I cannot say, but I do not think that the hair follicles are destroyed. I have had the best success in such cases by using some good disinfectant and the best for the hair is, I think, alcohol. I believe I should treat this case with alcohol mixed with some of the essential oils, or a mixture of this kind:

Oil of Lavander	1 drachm.
Alcohol	8 ounces.
Oil of Cloves	15 drops.

Alcohol is supposed to be a good disinfectant and a good parasitic agent and I think the above is the best proportion for such cases as this. For localized forms of alopecia I think that chrysarobin is the best remedy.

I think the prognosis is good in this case.

DR. SAMUEL SHERWELL.—Why not include in the treatment cod-liver oil, syrup of the iodide of iron, look to the general nutrition and keep the bowels regular? I should also apply some stimulant and lotion to the scalp, as for instance, one and one-half ounce each of Spts. Déstillat. oleum ricini and cologne;

about one-half a grain of bichloride to the ounce. I also add a little sulphuric ether and a little tincture of cantharidis and a small amount of resorcin and salicylic acid as well.

Dr. Edward B. Bronson.—I am glad Dr. Robinson referred to parasticism in connection with that disease. It seems to me that this particular case is most easily explained on the parasitic theory. It may be supposed that the acute inflammatory diseases that preceded it was associated with some severe injury that was the cause of the scalp affection, while there is no particular reason why a parasite should show itself just at this time. The circumstances in this case favor the neuropathic rather than the parasitic theory.

In regard to the prognosis of the case I should not despair. I agree with Dr. Fox that in alopecia universalis recovery may take place. I have seen the hair grow again after the alopecia has remained complete for years.

With regard to treatment, it is a fact that most of the medicine advocated in this disease are germicides, which would seem to favor the parasitic theory. But nearly all of them belong to the class of reducing agents and are keratoplastic remedies. Such a remedy is pyrogallol, which I have come to regard as perhaps the best of all. In one case in which several different remedies were applied persistently for a considerable period to different areas of a scalp affected with the disease pyrogallol fairly outstripped them all, the area to which that was applied (a 10 % ointment) showing at the end of the period a decidedly greater improvement than the other agent.

Dr. Andrew H. Robinson.—Did it have anything to do with the measles?

Dr. Bronson.—It was not only measles, but, according to the mother's statement, the child had pneumonia. That a neurosis with resulting trophic changes in the skin might follow such a severe illness it seems to me not improbable.

Dr. George Thomsom Elliot.—Michelson claimed that the cases of universal alopecia areata were parasitic. I have a case now at my clinic at Cornell University Medical College, in which the hair is growing under the use of $^1/_{15}$ of a grain of pilocarpin given hypodermatically once a week. The hair is growing over the beard, eyebrows, the scalp and the axilla. The case was of one and a half years' standing.

Dr. Prince A. Morrow.—The parasitic theory is based largely upon clinical evidence. Several years ago I read a paper before the Congress at Washington in which I made a review of testimony, pro and con, regarding the parasitic nature of the disease. We find that French literature abounds in cases which support the parasitic theory of alopecia areata almost as strongly as clinical evidence confirms the parasitic theory of ringworm.

I think it is a parasitic disease, as it readily responds to stimulating and antiparasitic treatment there is no disease that comes under my observation in which as a rule I am so hopeful of cure. I have had cases under observation in which there were a number of relapses during a period of several years, eventually followed by complete and permanent cure. I give an unfavorable prognosis in all cases where the alopecia has persisted for two years or more. So far as the clinical evidences of the parasitic theory are concerned they abound and super-abound. There are numerous well authenticated epidemics of the disease in schools, convents, regiments and families. Several cases have come under my observation in members of the same family when there was a reasonably clear history of contagion. The demonstration of the contagiousness of a disease comes with it, strong presumptive evidence, at least, of its parasitic nature.

DR. GEORGE HENRY FOX.—I should like to ask Dr. Morrow how he accounts for the fact that a large proportion of cases get well without treatment at all, or at least, with treatment that practically has no effect. Other parasitic diseases do not follow that course.

DR. SAMUEL SHERWELL.—This case referred to occurs at an age when parasitic diseases are not at all common. Another point made, referred to the reappearance of the hair in tufts; how do you account for that if this is a parasitic disease? I should think that if it appeared in tufts it would plead against the parasitic disease rather than for it; it would seem to me that it speaks more in favor of a neurosis.

DR. GEORGE THOMSON ELLIOT.—I should like to ask Dr. Morrow if there is anything more positive than clinical evidence that cases of alopecia areata are parasitic. All of us have seen cases get well whether treated or not. I have seen a number of cases treated by the most extensive parasitic means possible without effect. It would seem that this being the age of germs, one presumes that a disease uncertain in its pathology must be parasitic in nature. More, however, than presumption is necessary in establishing the fact, and most certainly, as far as alopecia areata is concerned, no definite proof of its parasitic nature has been brought forward. Dr. Robinson has stated that he produced areas of alopecia absolutely identical with those of alopecia areata by injecting in the scalp cultures of staphylococcus epidermidis albus (Welch). This staphylococcus is, however, a normal, so to speak, parasite of the skin, and being always present, why does it not produce its effects—alopecia areata—in every one. I do not believe that true alopecia areata is parasitic in nature, but that many cases so-called and which appear to be contagious are cases of bald ringworm or of some other unidentified affection.

DR. PRINCE A. MORROW.—As I stated before, the parasitic theory is chiefly based upon clinical evidence. There has been no evidence from the bacteriological side which proves conclusively that alopecia is a parasitic disease. Several observers have claimed to have discovered a parasite which they regard as the pathogenetic agent but they have not been confirmed. There are a great many diseases which we accept as parasitic where we have been unable to find the microbe —at least, it has never been identified as specific and peculiar to the disease in question; but from analogies of alopecia areata with other diseases which have been proven to be parasitic, from its peripheral mode of extension and course, and its response to parasiticidic remedies its clinical behavior seems to be more in conformity with the parasitic theory than with any other. In considering the trophoneurotic theory there are arguments just as strong against its nervous origin. How can you explain its origin from a neurotic condition in cases where there has been no traumatism, nerve lesions, mental shocks or general nervous debility, which could possibly account for it. In most cases the general health of the patient is perfect. I do not believe that the facts as observed fits in with the neurotic theory as well as with the parasitic theory.

There are numerous epidemics of alopecia recorded in literature, no such analogical evidence can be adduced in favor of vitiligo. Outbreaks of alopecia have been reported in the same school where it was a very common thing for the pupils to wear each other's caps. One of my cases reported at the Washington meeting was that of a young man with alopecia who was home from school on a vacation. His sister wore his cap and, soon after, returned to Smith College where, three or four months later, she developed an alopecia which

rapidly swept the hair from one-half her head, from the eyebrows, from the axilla and from the pubes. She recovered entirely, but her brother did not. I think the clinical evidence as furnished by the French writers is very conclusive. Certainly cases of vitiligo cannot be brought forward as parasitic in origin.

A Case of Atrophy of the Nails.—Shown by Dr. Bronson.

Dr. Bronson presented a case of atrophy of the nails shown at the meeting in February last. At that meeting the suggestion had been made by some of the members present that the syphilis from which the patient had suffered sixteen years before might, notwithstanding its symmetrical and other characters that did not correspond to syphilides of so late a stage, be the cause of the present affection. After a course of thorough antisyphilitic treatment pursued for three or more months no improvement whatever was noted, but the case became decidedly worse. For the past three months the patient has been treated with arsenic (arsenite of potash, 1/5 grain per diem and at present shows a very marked improvement. The nails are all growing well, the appearing of the new formed nail substance being perfectly normal.

Dr. Charles W. Allen.—I think this is a very good result. Arsenic I consider to be a good remedy in many affections of the nails, but I think one of the things we are apt to forget is that it may prove beneficial in some manifestations of syphilis. These nail changes sometimes prove to be extremely obstinate.

Dr. John A. Fordyce.—I should like to ask Dr. Allen in what manifestations of syphilis is arsenic good.

Dr. Allen.—In certain old skin and nail lesions which do not tend to go away, under mercury and iodides.

Dr. Samuel Sherwell.—I should like to ask Dr. Bronson if he gave mercury as well as arsenic.

Dr. Edward B. Bronson.—For the past four months he has been taking arsenite of potash, which has been gradually increased from about 1/5 up to 1/2 grain a day. Mercury had been given previously for a considerable period, but during this time the disease of the nails had steadily grown worse. The only local treatment was a bichloride lotion which was stopped four months ago.

A Case of Acne Varioliformis of Legs.—Shown by Dr. Bronson.

K., aet. twenty-four, of good build and healthy appearance, with good personal and family history, showing no evidence of tuberculous or syphilitic taint. About three years ago first noticed a peculiar lesion on the inner side of the right leg, midway between knee and ankle. It had the appearance of a small red spot that was partly scabbed over. It was slightly painful on pressure but no other sensation was noticed. It was observed that the spot gradually extended; whether its spread was altered with the formation of new lesions the patient is uncertain. There was never any distinct suppuration nor ulceration, though he remembers that at once the surface seemed slightly abraded and moist. When the scale or scab fell off a scar remained and nothing further occurred the patient thinks until March last—seven months ago, when other lesions of a similar character appeared on both legs. No disturbance of sensations, neither itching nor pain, attended the eruption, which but from its unsightly character would have never attracted his attention.

At present both lower legs are studded on all sides with dirty brownish red spots. These for the most part in size, vary from miliary to lenticular and some are larger. Nearly all the spots are slightly depressed below the niveau and atrophy. The larger ones usually show two or more independent seems or

atrophic depressions. On a large proportion of them there is a scale or scab in the center which is of a yellow color like favus, but the edges are free and they are easily detached. Underneath the scab the surface is of a dark purplish color and almost invariably cicatricial. Generally the lesions appear to have begun at the sites of hair follicles, and for the most part appear in little groups. On the inner side of the right leg the site of the original lesion of three years ago is marked by an oval depressed scar two inches long and one inch wide, showing on its surface several deeper depressions, each the size of a little finger nail. The color of the patch is brownish with the purple veins showing plainly. On the left leg are two similar large cicatricial patches, one on the peroneal aspect midway between knee and ankle, oval in shape and of about the same size as the patch on the right leg. The outer atrophy patch on the left leg is more round in shape and about one and one-half inch in diameter. The general appearance is that of some disease in the stage of involution. Nothing that looks like new or recent lesions are to be found.

DR. ANDREW R. ROBINSON.—It might be favus or it may be a tuberculide.

DR. L. DUNCAN BULKLEY.—It is undoubtedly a tuberculide.

DR. SIGMUND LUSTGARTEN.—I should say that it was a tuberculide, although it reminds me somewhat of an affection the French describe as beginning in the follicles, the inflammatory process extending into the derma, healing occurring with atrophy.

DR. CHARLES W. ALLEN.—When I first saw the case there were two or three small scales which suggested to me favus. Favus dips down into the tissues and I would keep this diagnosis in mind until it was excluded by the use of the microscope. If favus is not present I would look upon it as a folliculitis of some kind.

DR. FORDYCE believed the case to belong to the group of diseases which it is now the fashion to call "tuberculides." It is closely allied to the case described by Bronson several years ago as acne varioliformis of the extremities. The eruption is histologically a granuloma in which rapid necrosis of the new cell deposit takes place.

In the October number of the *British Journal of Dermatology* a case is described with similar clinical features in which tubercle bacilli were discovered.

DR. EDWARD B. BRONSON.—It resembles favus only in the color of some of the scabs. The scales are loosely adherent and are not cup-shaped; they are quite granular and there is no cuticle covering them. In fact, there is so little in which they resemble favus that I never seriously entertained the idea of its being that disease.

A Case of Tubercular Leprosy.—Shown by DR. ELLIOT.

Duration—about two years; location—face, arms and thighs. Tubercles, small shot to bean size scattered over thighs and arms. Appeared first on forearm and reaching bean size, began disappearing and are now about split-pea size. Patient states all the tubercles are growing smaller and no new ones are appearing.

DR. GEORGE THOMSON ELLIOT.—The man has improved in a remarkable degree under chaulmoogra oil. The patient entered the hospital on the 4th of October and has been but eighteen days under treatment and the lesions have improved decidedly. He is now getting twenty drops of the oil three times a day; he takes it in milk and it agrees with him.

DR. PRINCE A. MORROW.—I would say that it seems to me from my observa-

tion of a large number of cases of foreign lepers who have come to this country that it is very difficult to differentiate between the results of treatment and the improvement which naturally follows the changed conditions of food, country and climate. I have seen several cases of tubercular leprosy improve materially without any treatment, the nodules diminishing in size and I remember one case, a man from Brazil, who had large anesthetic areas upon the abdomen and thorax, which cleared up and the sensibility returned with practically no treatment. In saying this I do not wish to depreciate the value of chaulmoogra oil, because I believe that, in some cases, it is of value.

Dr. Elliot.—The patient has been in this country for some time. He has had a change from an out-door life to the hospital life.

Dr. Morrow.—Has the nutrition improved?

Dr. Bronson.—The nutrition was perfect when the patient came in. He has been here at least six months. It seems to me that, in this case, we can attribute some of the change to the chaulmoogra oil which he has been getting for only two and a half weeks; there is a decided change in the lesions and in his general appearance.

Dr. Morrow.—Does he tolerate the oil well?

Dr. Bronson.—Only when taking it in milk.

Dr. Morrow.—I have had a number of patients who could not take the chaulmoogra oil put up in this city, yet they could tolerate the oil which was put up in capsules by a firm in Paris without difficulty. I have noticed this particularly in three cases. Now, whether this was due to the chemical qualities of the oil, or to the more refined product, being freer from impurities, could not be determined. I have used in cases when the oil could not be tolerated the gynocardate of sodium, and I would suggest its use in Dr. Elliot's case.

A Case for Diagnosis.—Shown by Dr. Elliot.

Location, general; duration, about five years; started on inside of right arm, patient next noticed white blotches on neck. At time of admission to hospital skin showed an infiltrated fissured bleeding surface generally, hands badly fissured. Body presents circular and semi-circular patches generally; considerable weeping, especially on back, chest and axilla; lower part of body and legs presenting a dryer appearance and some scaling.

Dr. Sigmund Lustgarten.—This is an interesting case and is probably one showing the early stage of mycosis fungoides.

Dr. Prince A. Morrow.—I should recommend that Dr. Elliot take a photograph of this case, showing the condition especially of the forehead. We have pictures in skin atlases showing the pre-mycosic stage of mycosis fungoides and also fungoid, the stage with characteristic tumors are well developed. Here is a case in which the tumors are just beginning to sprout, or develop upon the forehead and illustrate a characteristic phase of the disease. I think that a picture of this case would be an excellent contribution to the pictorial representations of mycosis fungoides.

Dr. Samuel Sherwell:—How long has the eruption existed?

Dr. Elliot:—Five years.

The improvement in this case was also something remarkable, the patient being put on chaulmoogra oil; really, the improvement was something marvelous. I have seen the same result in a case in private practice where the disease has been going on for seven years and was completely controlled by chaulmoogra oil during the past few years. Once or twice a year small fungoid

tumors sprung up. The patient was given chaulmoogra oil in pill form, five drops in each pill, and twelve being taken each day, an equivalent to sixty drops a day.

DR. PRINCE A. MORROW:—That is the logical treatment of the case which is designated by the French "indigenous leprosy." I think I should try cacodylate of sodium which I have used both by the hypodermic method and by the stomach, and which has such remarkable results in bettering the nutrition of the skin.

A Case of Lichen Planus.—Shown by DR. FOX.

Girl, 8. Lichen planus, two months' standing. Rapid evolution of disease, the lesions losing color and flattening under R. & S. Eruption limited chiefly to trunk.

Man with hypertrophic lichen planus lesions on back of hand, a few on leg of one month standing, and typical lesions on body.

DR. CHARLES W. ALLEN:—Since the question of diagnosis has come up in the case of the little girl, I should say that it was undoubtedly a case of lichen planus.

DR. JOHN A. FORDYCE:—I think it is rather unusual and unique to see such a condition in so young a child.

A Case of Morphœa.—Shown by DR. ALLEN.

DR. ALLEN presented a private patient, 26 years of age, whom he had shown a year before with patches of morphœa upon the cheek. Treatment had been carried out by means of the electrolytic needle with favorable results.

DR. CHARLES W. ALLEN:—I have also recently had a little girl with morphœa involving areas over both thighs and legs, which is nearly well under the use of electrolysis. The plaques here occur in bands and rounded plaques up and down the leg.

A Case for Diagnosis.—Shown by DR. DADE.

DR. PRINCE A. MORROW:—I think this is a case in which the diagnosis lies between dermatolysis and fibroma molluscum. It might be termed fibroma molluscum, although in fibroma molluscum we usually have the tumors more generalized and more sharply defined and delimited, smaller in size and of different consistence.

DR. GEORGE HENRY FOX:—I should regard it as a hairy nævus which must have been congenital.

DR. JOHN A. FORDYCE:—I agree that it is probably congenital and that it has increased in size.

DR. CHARLES W. ALLEN:—I think that it is a congenital nævus.

DR. SIGMUND LUSTGARTEN:—I am inclined to look upon it as a case of fibroma molluscum. There seems to be a number of pigmented lesions upon the body and a close examination may reveal the pigmented soft tissue which shows it to be very rich in embryonic cells and young connective tissue. If it is a simple nævus it has too many unusual features. I think it is an unusual case of fibroma molluscum.

DR. EDWARD B. BRONSON:—I trink the term dermatolysis is an unfortunate one. This term should only be used where there is great looseness of the skin. In this instance there appears to be a distinct hypertrophy of all the tissues of the skin differing in that respect from molluscum, which is characterized by an increase in the loose connective tissue, which is protruded through the cel-

lular epidermis. Here all the elements of the skin are increased including the pigment. The term Pachydermatocele is more applicable than Dermatolysis.

DR. L. DUNCAN BULKLEY:—I do not think we should apply the term pachydermatocele to this case, but molluscum pendulum. There are many cases like this having also nævoid connections. Under the microscope we may probably find it to be a case of fibroma molluscum.

DR. ELLIOT:—Whether this is a fibroma molluscum or a nævus molluscuformi I do not know and I should like to examine the case more closely before expressing an opinion.

A Case of Pruritus Hiemalis.—Shown by DR. BRONSON.

DR. GEORGE HENRY FOX:—This seems to me to be an interesting case of pruritus, purely neurotic in nature, with some secondary lesions of the skin produced by the scratching. Hiemalis is a term that I do not like, for there are many skin diseases that are worse in winter and the term might be even applied to eczema and other diseases as well as to this one.

DR. L. DUNCAN BULKLEY:—I think the papules are secondary lesions, the result of the scratching, because they heal without any tendency to exudation. I like the use of the term pruritus hiemalis, because so many cases appear during the winter.

DR. BRONSON:—Perhaps I owe an apology for presenting this case before I had studied it longer and had obtained a completer history. However, the patient has distinctly told me that the trouble has been worse every winter during the past three years. It is a temperature itch, and it is at least aggravaed in winter. The cutaneous lesions are quite insufficient to account for the pruritus and such as they are are clearly traumatic and from the effects of the scratching.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

Wednesday Evening, November 20, 1901.

W. K. OTIS, M.D., *Chairman.*

PRESENTATION OF CASES AND SPECIMENS.

DR. GUITERAS:—Mr. President, I have two kidneys here which I removed last Tuesday afternoon. The first specimen I think is one of hydronephrosis. It has not yet been submitted to the pathologist and it may possibly be a kidney containing multiple cysts, but I think it is hydronephrosis. This patient entered the hospital about six weeks ago, having been sick for two weeks. His trouble followed a fall which he had had two weeks previous, at which time he landed on his left side. After that he began to have pains in the left loin and the abdomen gradually increased in size until when I saw him in the hospital the whole abdomen was distended, so that it resembled a gravid uterus at full term. From the history of the case, the location of the pain and the fact that the left loin was a little fuller than the right, although the patient had no symptoms of renal colic and had no symptoms previous to the fall which indicated kidney trouble, it seemed to me that his condition depended upon his kidney. As I

did not know just what I had to deal with, I made an anterior incision first over the region of the kidney. I cut down into the peritoneal cavity and found that the visceral and parietal layers came together in such close approximation that the collapsed intestines were spread out like ribbons, lying flat on the posterior peritoneal surface, which was pushed up against the anterior abdominal wall. This exploratory incision satisfied me that I had to deal with an accumulation behind the peritoneum, which was probably fluid and the result of a ruptured kidney. I evacuated three and a half gallons of blood and urine. It was of a light permanganate color. I could then feel in the lower border of his kidney a rupture. I could put my finger in through this rupture to the kidney pelvis, which I examined down the ureter a little way without being able to feel any obstruction, then as the patient's condition was bad I closed him up again, having fastened a drainage tube in the pelvis of the kidney. The patient did very well for some days and then his temperature and pulse began to go up and his abdomen become very much distended again. I found that the large catheter which I had put into the pelvis of the kidney for drainage had slipped out, and the house surgeon, in dressing the wound, had pushed it in between the skin and the erector spinæ muscle. I opened the space posterior to the kidney and about a gallon of a yellowish fluid, which proved to be a mixture of urine and pus, gushed out. A tube was put in and for about five weeks the patient has been draining through the loin. He has run a temperature of from 99 to 101 and a pulse from 90 to 110. As he had become anemic and cachectic, I decided to remove the kidney. Accordingly, on Wednesday I opened my incision again and found the kidney, which consisted principally of a very large sac. There was some kidney tissue left, but the sac was very noticeable, probably resulting from the distention of what had been a hydronephrosis. There were a great many adhesions present, which were liberated with great difficulty. The pedicle of the kidney was, I should think, from four to five inches wide, with a number of large veins running through it. After trying for a long time to free the kidney so that I could remove it, the patient's condition became such that I was obliged to dissect the pedicle and leave in a part of this sac of the hydronephrosis. The ureter was very much distended, I should say just at the junction of the kidney, at least the size of the wrist. I did not follow the ureter down, as I had intended, on account of his condition, but I am of the opinion that there is a probable stone in the lower part of the ureter, near the bladder. This patient is now doing fairly well. Perhaps later on I will make another incision and see if I can find the stone.

The second specimen is a kidney I removed from a boy of 20, who came in the hospital about two weeks ago—a week before the operation. This patient had a history of being sick for about three weeks previous to his entrance. He had had pain and swelling in his left lumbar region. Temperature on entering was 104; pulse was 110. The patient had been kept in bed, given diluents, until his temperature went down gradually to 101, his pulse to 90 to 100. The kidney could be very clearly outlined; came down about 1½ inches below the umbilicus and extended further than it should in each direction laterally. I made an incision in the lumbar region, exposed the kidney and examined it. It seemed to be tuberculous. It was enlarged, inflamed, and there were numerous small abscesses in its upper pole. I present the specimen for examination. The patient was put to bed and during the first twelve hours he passed sixteen

ounces of urine; that was up to noon of last Thursday, six days ago, since which time he has passed no urine at all—complete suppression. His condition is still fairly good, however. Pulse ranges from 100 to 110. He is conscious, although, of course, his mental faculties are not clear. He has had no uremic symptoms, although he seems to be gradually sinking into an uremic condition. We have tried everything we knew of—internal medication, hot packs, cupping, digitalis poultices, the hot rectal douches, rectal irrigations—nothing seems to start his urine. Every day he is catheterized twice and no urine has yet been drawn. This patient's urine had shown evidences of renal disease. He has had blood, albumen, renal epithelium and casts.

Epithelioma of the Penis.

Dr. Pedersen:—This specimen was removed from a patient 45 years old. As described by the patient, the growth began some two years ago in the form of a small nodule, that appeared on the inner surface of his foreskin. It grew very slowly and it was not until early last summer that he called his physician's attention to it. His physician passed it over as a trifling matter at first, but later, after a consultation, circumcision was performed and the base of the now warty growth was thoroughly curetted. This was last August. From that moment on the lesion grew very rapidly, and the patient was brought to Bellevue Hospital about two weeks ago. The patient had declined operation at an earlier date, his physician tells me, and it was only after the ulcerating mass eroded the blood-vessels and two or three very sharp hæmorrhages had taken place that he had consented to undergo a radical operation. While in the hospital, and before we had an opportunity to take a section of the growth, he had a severe arterial hæmorrhage. Two good sections were taken and the pathologist reported typical epithelioma. Nine days ago I did a circular flap amputation and removed the penis close to the tissues at the pubes. The small stump is flush with the tissues of the pubes. An inlying catheter was maintained until the fourth day and then removed. Healing took place by primary union.

Urethral Calculus.

Dr. T. M. Townsend: —In Dr. Valentine's absence this evening, I beg the privilege of presenting this case on his behalf:

On November 14th Dr. V. Sellaro brought to the office G. J., Italian, married, laborer, aged 45, the father of two children.

The patient had had one gonorrhea five years ago, which appeared four or five days after suspicious intercourse and, according to the patient's recollection, lasted two or three weeks. This only attack was not attended by complications, nor had it any sequelæ which the patient recalls.

Three years ago, without any precedent symptoms, he was suddenly taken with dysuria, swelling of the penis, followed by bloody urination. The patient does not recall whether his urethra bled independently of urination nor how long the discharge of blood continued. Throughout, efforts at obtaining a precise history were in a great measure ineffectual, owing to the patient's limited powers of observation.

He said, however, that neither erections nor coitus were painful since the attack he described.

The external genitalia were normal to inspection, except as to a free thick whitish excess of urethral secretion which presented at the meatus.

The first urine (150 cc.) was clear and contained coarse thick shreds, long and medium, coarse filaments which sank to the bottom of the tube.

The second urine (60 cc.) was clear, with fewer floaters than the first.

Urinalysis made on the following day by Dr. Louis Heitzman showed:

Specific gravity, 1028.

Reaction, acid.

Albumen, none.

Sugar, none.

The features under the microscope are:

Crystals and concretions of oxalate of lime in rather large numbers.

Pus corpuscles—in moderate numbers, many containing fat globules.

Epithelia from urethra and prostate gland—few to moderate.

Epithelia from pelvis of kidney and ureter—few to moderate; with some fat globules.

Epithelia from convoluted tubules of kidney—few.

Mucus—abundant.

Red blood globules—few.

Epithelia from upper and middle layers of bladder—few.

The microscopic diagnosis therefore would be *Pyelitis calculosa.*

Palpation of the penis showed at the junction of the middle and posterior thirds of the pendulous portion in the lower aspect of the right corpus cavernosum and involving the corpus cavernosum urethræ, a very hard, rough, irregular body, firmly imbedded in the tissues.

Tactile exploration of the urethra with a rigid sound (21F.) conveyed the sensation of the anterior surface of a dense stricture at the junction of the middle and posterior thirds of the pendulous portion. In addition to this resistance there was a rough grating as of a stone with a very coarse surface. This stone was immobile.

Urethroscopic examination was necessarily limited, as the meatus would admit no instrument of a larger caliber than 21F. On reaching the point above described, a dense, white circular cicatricial band could be clearly discerned; on pressing the tube against this band a small part of the stone could be brought into its lumen.

Attempts at removing the foreign body through the urethroscopic tube proved futile, as its greater part was firmly imbedded in the tissues, even had it been movable, its size would have prevented its extraction through the tube.

Removal of the calculus was accomplished as follows: A Dittel serrated foreign body forceps was inserted through the stricture, and while the stone was steadied with the left fingers the tissues holding the stone were gently scraped from its surface, by first placing the jaws of the forceps closed upon the exposed surface of the stone, then slowly opening them, following the irregular contours of the stone. When the mucosa covering the calculus had been pealed from it in this manner, it was found that the alligator jaws of the forceps were not large enough to grasp the stone. Hemostatic forceps with long, narrow jaws were then inserted, the stone grasped, and after gently turning it to find the line of least resistance it was laid free in the urethra and withdrawn.

Not more than 5 cc. of blood were lost in the operation.

After removal of the stone a 5 per cent. suspension of iodoform in glycerin was injected.

Presentation of Patient for Diagnosis.

DR. GUITERAS.—This man is a driver, 21 years of age. He states that six months ago he had ulcers on the penis, lasting for four weeks. Following this he had sores in the mouth and slight sore throat. Two months ago the patient noticed that the lymphatic glands in the right side were enlarging and becoming painful. Two weeks later small abscesses appeared on the inner and posterior surfaces of the right thigh. Some would heal and others break out. They itch, are tender, break, discharge a dark, gummy substance containing blood and pus. I present the case as one of bubo with a peculiar complication that I do not feel sure of and as a doubtful case of syphilis.

DISCUSSION.

DR. JOHNSON.—In the first case the result seems to have been very satisfactory. In the second specimen which Dr. Guiteras has shown, although I should hesitate to pronounce any positive opinion upon the appearance of the specimen in its present state, yet it certainly closely resembles to my eye a pyelonephritis with a localization in one pole of the kidney. There are upon the surface of the organ a number of yellowish nodules elevated above the surface and an induration of a portion of the kidney beneath these nodules, which would rather indicate to me that the disease is of that type. Possibly, of course, it may not be. I would not like to express it very positively. At the same time it is not beyond the bounds of possibility that the disease in this case may have been bilateral.

DR. BOLTON.—The first case, the hydronephrosis, illustrates very well one of the main advantages of the transverse incision for exposing the kidney. If that scheme had been adopted and an incision made parallel to the border of the ribs from the erector spinæ muscle forward, even as far as the rectus muscle, it would have been a very simple matter to incise the peritoneum at the anterior angle of the incision and open the abdomen without the necessity of turning the patient at all.

DR. BIERHOFF.—With reference to the first case Dr. Guiteras presented I note that he expressed some doubt as to whether there was present vesical calculus, or vesical calculi, or a urethral calculus. I am surprised at that, for the deciding of that question is so very easy that in a case of mine I should prefer to decide that before operating.

In regard to the second case several questions arise. The first is, why did Dr. Guiteras remove that kidney? The question is, On what did Dr. Guiteras base his diagnosis of tuberculosis of the kidney? If I understood the report of the case correctly, there is no mention made of the bacillus tuberculosis having been found. How did Dr. Guiteras decide that there was a second kidney present? How could he know what was the condition of that second kidney, if there was a second kidney present? And finally, I would say it seems to me, from listening to the report and the subsequent history of the patient, that it is not at all unlikely that Dr. Guiteras removed a healthy, somewhat hypertrophied kidney, which was performing the function all by itself—its own functions and those of the other diseased kidney. If I may sum up my remarks upon the second case, I should say that its chief value to us must be as a warning of what not to leave undone.

DR. GUITERAS.—With regard to the first kidney and whether the patient has had hydronephrosis or not I do not know. Nothing in his previous history

pointed to it, although the history of the accident indicated it and the operation confirmed it. The reason I made the anterior incision was because it was a case where I was not sure of my diagnosis, and as the tumor was so large I thought by an incision anteriorly that I could explore more satisfactorily.

In the second case there were no tubercle bacilli found in the urine, although the urine was not examined by an expert. The history of the patient, the record of temperature, the feeling of the kidney by examination and palpation, the urinary examination, all tended to show me that the kidney was enlarged and acutely inflamed; but it was not until I had made my incision and freed my kidney that I came to the conclusion that it was a probable case of tuberculosis and should be removed. It may, however, be a case of pyelonephritis, but there was no pus in the urine, and it seems to me rather rare to find a case of pyelonephritis without having pus in the urine. Of course it may have been a case of suppurative kidney where the foci of suppuration have developed through the blood and had not ascended from the pelvis of the kidney. The patient, however, has had no cystitis and no pyelitis, as was determined by urinary examination.

DR. BOLTON.—It is quite interesting from a diagnostic point of view to realize at what an early period of life these carcinomata of the penis may develop. In the last three years I have seen three patients with carcinoma of the penis—one 27, one 26, and one 23 years of age.

DR. MANLEY.—I would like to ask Dr. Bolton about the history of those three other cases because I have seen quite a number of cases which had been diagnosed microscopically as epithelioma in young men which had turned out by treatment to be chancroids, and that was the reason why I should like to inquire what was the final outcome of those three cases which had microscopically been diagnosed as epithelioma.

DR. BOLTON.—One of them I saw at Bellevue Hospital, pronounced carcinoma. The other two at the New York Hospital, pronounced carcinoma there. The patient in whom the disease developed at the age of 23 had also a glandular deposit in his groin. I saw him the other day and he had a recurrence in the groin.

THE CHAIRMAN.—I have had to deal with quite a number of these urethral stones and haven't found the endoscope of any service in removal. On the contrary, they are much more easily removed through the urethra with the forceps in the way in which this one was removed or else pushed backwards into the bladder and crushed with a small lithotrite.

DOCTOR KLOTZ.—I was not present when the history of the case was reported, but from their appearance I believe that some of the conditions found on the patient are due to syphilis. The soft swellings in and around the groin I consider as suppurating glands not of gummatous origin, and the lesions on the scrotum as simply foci of suppuration due to some pus infection. But there is a larger, coherent patch of slightly scaly, flat papules on the inner aspect of the right thigh, which I do not doubt is of syphilitic origin.

DR. LAPOWSKI.—I consider the case as a plain follicular infection.

THE SECRETARY.—I am inclined to agree with Dr. Lapowski.

DR. PEDERSEN.—I am inclined to agree with Dr. Lapowski. I would not be willing to say there was a syphilitic character to the lesions present in the groin and the upper part of the thigh. I had under my care at the Post-Graduate Hospital two or three summers ago a patient similar to this one, both in his

physical appearance and in the character of the lesions present. These proved to be a mass of infected glands in various stages of suppuration. A very radical dissection was required to clear them out.

DR. GUITERAS.—I never saw the case before last night, and the history of syphilitic trouble is not clear. I did not present him on account of his general condition, although, of course, that is interesting. I presented him particularly for the condition in the groin and on the inside of the thigh. I did not know whether it was folliculitis, tuberculosis of the skin, or what the condition was, or its relation to the bubo.

The Surgical Treatment of Certain Suppurative Conditions of the Kidney.

DR. A. B. JOHNSON read a paper with this title.

The lesions considered were:

1. Acute pyelonephritis with the production of miliary abscesses.
2. Pyonephrosis.
3. Localized suppuration in the kidney (kidney abscess).
4. Hydronephrosis with secondary pus infection.

The operative treatment of these various conditions was discussed, especially the question as to whether nephrotomy or nephrectomy was to be the operation of choice. Several instances were related in which nephrectomy had proved a life-saving operation in cases of acute pyelonephritis involving one kidney; and several cases were quoted from the literature of the subjects showing that when but a small portion of one kidney was involved in the process partial nephrectomy had been successful.

Pyonephrosis was spoken of at some length.

The writer drew the conclusion, based upon the nature of the lesions, upon the experience of others, upon certain statistics quoted, and upon his own experience, that nephrectomy, rather than nephrotomy, was to be regarded as the operation of choice.

The treatment of localized suppuration in the kidney—kidney abscess, so-called—he believed, on the other hand, should be conservative. Hydronephrosis with subsequent infection of the sac was a condition permitting the successful use of a variety of conservative operations chosen to fulfil the particular indications of the individual case.

The septic complications were not usually so menacing as in cases of pyonephrosis.

In certain cases incision and drainage could be followed later by a suitable plastic operation for the reëstablishment of a direct channel of communication between the kidney and the urinary bladder. In general nephrotomy was the operation of choice.

DR. BOLTON.—This question is such a large one it is difficult to attack it at more than one point at a time. The novel proposition that is before us is to attempt the relief of the patient suffering from acute suppurative pyelonephritis by surgical means. This condition very usually up to within a few years was regarded as almost inevitably fatal. The first case of this kind that came under my observation is a rather interesting case. It extended over several years. It was a man, say 27 years of age, who had had scarlatina a few years before I saw him and in consequence of that had at the time chronic nephritis of moderate severity. When I saw him he had a posterior urethritis which quickly extended to the bladder. I sent him to St. Luke's Hospital under the care of

Dr. Bangs. He was there for some time and the severity of his symptoms decreased to such a degree he was able to leave the hospital. Two or three months later he became septic; had chills; had a septic temprature of 105° in the afternoon, 102° in the morning, and with that had pain and tenderness in both loins, which was more marked on the right side than on the left. In this condition he was sent to the New York Hospital under the care of Dr. Weir, who exposed the right kidney, in which the pain was more marked than in the left, and extirpated it. On incision the kidney was found to be twice its normal size, presenting in section typical pyleonephritis. The general symptoms of sepsis almost at once subsided without any trouble, and at the end of six months the patient's urine was practically the urine of one suffering from a mild degree of chronic nephritis. Specific gravity about 1010 to 1012 containing a little albumen. For the next year the patient enjoved a fair degree of health, and at the end of this time he began to suffer from a progressive chronic nephritis, from which he went on and died. He unquestionably had a bilateral pyelonephritis added to chronic diffuse nephritis. He went on and died of his chronic diffused nephritis, and whether this was aggravated or influenced in any way by the occurrence and the disappearance of the pyelonephritis I am unable to say.

DR. GUITERAS.—The paper of Dr. Johnson was an interesting one and I must congratulate him upon the results he has had; also the results obtained at Roosevelt Hospital, because they are the best statistics I have yet had the pleasure of listening to or read.

In regard to the question of pyelonephritis it seems to me that Dr. Johnson's views coincide with mine. Perhaps in cases of calculus, where there is one large abscess, the calices of the pelvis being involved, and some of the kidney tissue secondarily to it, a nephrotomy might be the better operation, and after removing the stone and satisfactory drainage the kidney might perhaps regain its function and the suppurative processes cease. In all tuberculous cases, though, it seems to me if the kidney be involved the best thing to do is to remove it. If the kidney is not removed and a nephrotomy is performed, then we have exactly the tuberculous sinuses spoken of. These tuberculous sinuses last a long time—may last for years, and the suppurative condition is such that the patient's general condition is very much affected by it. I have a patient now under observation upon whom I performed a nephrotomy some years ago for tubercular abscess of the kidney and who still has a discharging sinus. I think now I should have performed nephrectomy, as the patient has amyloid degeneration of the liver and I presume of the other kidney.

Again, secondary nephrectomy that Dr. Johnson speaks of is a most difficult operation. No one knows unless they have had the misfortune I have had to operate on certain cases two or more times how difficult it is at times to remove the kidney. In doing ordinary operative surgical work on the kidney and in cases of primary nephrectomy we do not have the mass of adhesions to deal with that we do when we attempt some of these cases of secondary nephrectomy. The adhesions going upward toward the suprarenal capsule and those descending along the ureter are sometimes from two to three inches in width and an inch in thickness. It is almost impossible to dissect away the adhesions of this kind and we very often have to clamp, dissect and ligate again as in the case I spoke of to-night. The pedicle is often very wide, the vessels are all held together by adhesions, perhaps not in a small mass, but over a wide area. There-

fore it is hard to ligate the pedicle in such a case. Very often when you try to push a clamp or needle through this mass of spread out pedicle you will injure one of the veins, and also in freeing the adhesions you are liable to cause a hemorrhage.

In regard to the incision and the position of the patient, recently I have been operating on cases, putting a sand bag under the opposite loin, having the patient on his side, and having under the neck a log or sand bag of about similar size, between three and five inches in height, and having the shoulder of the side on which I remove the kidney a little more turned backward than the other one. In that way we have the erector spinæ muscle almost on a level and if we have made a free incision from the anterior superior spine to the twelfth rib and have retracted the abdominal wall we can have a better view of the pedicle than by any other position that I know of. The incision that Dr. Bolton spoke of—the transverse incision parallel to the lower rib—is without doubt one which gives us a good view of the kidney and a good approach. Personally, however, I am in the habit of making an incision from just above the anterior superior spine of the ilium curved up to the twelfth rib. I find from an incision of this kind that I have a very good control of my kidney, and that I can work as well, if not better, than by having the incision parallel to the lower rib.

DR. MANLEY.—This subject is one which I am very much interested in because in the last few years I have seen quite a few of them. I am fond of asking questions, Mr. President; it is a weakness of mine in societies, but I would like to ask Dr. Johnson as to what proportion of females he had in this number of cases of pyelonephrosis as I do not recall, Mr. President, ever having seen a single case in the male.

As to the mode of procedure, the radical operation, the statistics of the American surgeons are decidedly against this, and all the foreign writers, with the probable exception of Israel, in regard to the mortality from the simple incision and drainage and the removal of the kidney—nephrectomy. The question might be asked, Mr. President, as to whether nephrectomy is an operation which is warranted at all unless the kidney is practically totally destroyed. One might say if there are local areas of pus scattered through the kidney substance or parenchyma that it is pretty sure to involve systemic poisoning and ultimately lead to serious results; but that has not been my experience. I have seen quite a number of cases where there was a pretty well marked enlargement over the lumbar region of the abdomen, where there was pus thrown out in considerable quantities at the urethra, with all the histological characteristics of renal, that is, there were the pelvic and the renal epithelia, where patients had made very good recoveries. This process appears to be practically identical with that which we often observe in pyosalpynx, where the pus opens and drains off through the arteries (*sic*). In a case where the kidney is extensively destroyed and nothing remains but a shell, in that class of course the removal of the remains is from a theoretical standpoint the only procedure; but in those instances which have come under my observation of that class, all of them were in a very exhausted state, in very bad shape for the operation of nephrectomy—just that class which Dr. Johnson classes as that which will not warrant an extensive operative procedure. The operation, from what I have seen myself, what I have done myself, what I have seen in the hands of experienced surgeons, has been attended with a pretty large mortality, and hence in my opinion even though a fistula should be left, unless the patient's condition is such as to warrant so severe an

operation, it is a question whether or not we should do the tentative rather than the operative procedure. It is said fistula was left after nephrotomy, but I can recall to mind quite a few cases where nephrectomies have been done where the fistula has remained, even after the kidney had been removed.

DISCUSSION CLOSED BY DR. JOHNSON.

DR. JOHNSON.—I am unable to accurately answer the question in regard to the sex of these patients, but I may say that a certain proportion of them were men and a certain other proportion were women.

Selections.

GENITO-URINARY DISEASES.

Removal of Two Hundred and Eighty Grains of White Wax from the Male Urinary Bladder.—DR. ORVILLE HORWITZ. (Procedings of the Phil. County Med. Soc., 1900).

G. L., twenty-five years of age, was admitted to the wards of the Jefferson Hospital during last September. He complained of a frequent desire to urinate, followed by hemorrhage at the termination of the act. Pain, referred to the neck of the bladder and to the meatus of the penis, was experienced at the end of micturition. He stated that, twenty-four hours previous to his admission he indulged in sexual intercourse and, in order to prevent his mistress from becoming impregnated, he inserted into the urethra a roll of white wax, eight inches long and about twenty-six millimeters in circumference. This was passed into the urethra until its end was just within the meatus. Almost immediately after intercourse had begun, he felt the wax bougie slip into the bladder, the sensation was associated with a good deal of pain. On completing the act he discovered blood oozing from the meatus and felt a burning, stinging pain in the vicinity of the neck of the bladder. The introduction of a stone searcher readily detected the foreign body. Suprapubic cystotomy was performed, and, on opening the bladder, it was found that the wax had become rolled up in the shape of a large ball. On attempting to deliver it by means of the lithotritic forceps, the blades of the instrument became buried in the soft mass and when traction was made the wax was pulled out in a long thin strip, which could be stretched several inches beyond the abdominal incision. In order to remove the mass, it became necessary to insert into the bladder the index fingers of both the right and left hand, to grasp the mass and mold it into the shape of a sausage. By this means it was brought to the outer edge of the abdominal incision, where it was grasped by hemostatic forceps and held until it was caught at a point below by means of a second pair of forceps, thus gradually, hand-over-hand, it was finally removed. It was deemed fortunate that the suprapubic route was chosen in preference to the perineal, for, had the latter operation been selected, it would have been impossible to have removed the wax, and the bladder would probably have been a good deal damaged by the attempt. The wax had to be grasped with the forceps while in sight, the touch being deceptive, the soft wax feeling exactly like the wall of the bladder. Many strange foreign bodies have been removed from the bladder, but, so far as I know, the history of this case is unique.

Therapeutic Reports

CICATRICIAL STRICTURE.

By M. A. Auerbach, Ph.G. M.D.

Relative to the results obtained as reported by a California physician in stricture by injections of Glyco-Thymoline. Since that time I have treated nine cases of stricture, and watched them from time to time with the urethroscope and have come to the conclusion that Glyco-Thymoline does not cause absorption of scar tissue as was at first supposed, but of the reorganization of the same. The writer could notice upon the frequent urethroscopic examinations made in succession upon same individual the increased vascularity of the mucous membrane immediately surrounding the cicatrix. The funnel-shaped cicatrix, after a very short time, took on a rosy healthy color and from the funnel shape, became tubular, the natural form of the urethra.

The injections varied from 50 per cent. to 75 per cent. in strength; only the first injections causing any discomfort. My longest case took about two weeks and half.

Case No. 1.—Mr. J. E., age 22, Water street. Had great difficulty in passing water. It took him usually three times as long to urinate as his companions, and it passed from him in a forked stream. An examination revealed a stricture of the posterior urethra, through which a No. 14 Fr. sound would not pass. After five days of injections (Glyco-Thymoline), 50 per cent. solution, a No. 18 Fr. could be easily passed. The strength of the injections was increased to 75 per cent. and kept at this strength until a cure was affected. After 16 days of treatment a No. 30 Fr. sound could be easily passed causing no pain.

Case No. 2.—Mr. B. L., Forsyth street, called upon me with all the symptoms of a case of stricture. Examinations showed a stricture of the middle urethra and another of the anterior urethra. Patient was at once put upon a 50 per cent. solution of Glyco-Thymoline (Kress) injected twice daily. In nine days a No. 28 Fr. sound could be passed without using force, and patient was then discharged as cured, No. 28 Fr. being the normal size of this urethra.

Case No. 3.—Mr. H. M., Allen street, on urinating the water only dribbled from him, causing him to take from fifteen to twenty minutes to empty his bladder. It was with great difficulty that even a filliform catheter was passed. The stricture was situated about in the middle third of the pendulous urethra. Injections of a 75 per cent. solution of Glyco-Thymoline (Kress) was forced into the strictured urethra twice daily with the gratifying result that after five days of the above treatment a No. 14 Fr. sound could be passed. After two weeks of the above treatment my patient took a No. 30 Fr. sound without pain.

Case No. 4.—Mr. D. R. L., complete occlusion of the urethra with retension of urine. Was called 2 A. M. to see patient and relieve condition. I found

it a very difficult task to even introduce a filliform catheter past the stricture for such it was, but after considerable teasing was at last enabled to draw of the urine and relieve the pain. I had the gentleman call upon me early the next day for treatment at my office, which consisted of 50 per cent. injections of Glyco-Thymoline (Kress) thrice daily. This treatment was kept up for twenty consecutive days, after which period a No. 30 Fr. sound was passed with ease.

Case No. 5.—Mr. M. B., 125th street, passed a very small and irregularly shaped stream of urine which caused considerable discomfort. The urethra was so tender that it became necessary to anesthetize it with "Nirvanin" before a sound could be introduced to ascertain the position of the stricture which proved to be in the posterior portion. Glyco-Thymoline (Kress) in 50 per cent. strength was injected twice daily until a cure was made, the same taking twelve days.

Case No. 6.—Mr. R. DeL. gave a history of three attacks of gonorrhea, the last one followed by a stricture for which he came to me seeking relief. The stricture was situated in the anterior portion of the urethra and was easily reached with a glass syringe. Injections of a 50 per cent. solution of Glyco-Thymoline (Kress) were instituted twice daily, resulting in a perfect cure after fourteen days.

Case No. 7.—Mr. Martin K., Lexington avenue, came to consult with me for, as he explained it, an unexplainable condition of his bladder. Upon close questioning I elicited the facts in the case, which are as follows: Six months ago patient had an attack of gonorrhea, which he cured himself with one of the popular injections. The discharge stopped after two months' continuous use of the injection, and he also noticed that the volume of his stream of urine was not alone diminished, but that it required more time to pass it and also more force. A No. 18 Fr. sound was passed with considerable pain and great difficulty. A solution containing 50 per cent. of Glyco-Thymoline (Kress) was injected twice daily. After ten days a No. 28 Fr. sound was easily passed, and after 14 days a No. 30 Fr. was easily taken.

The remaining two cases being so similar to the preceding ones it will hardly be necessary to burden you with them.

In conclusion, however, I would like to make mention of a case of stenosis of the os uteri, which I have under my care and which has been greatly benefited by eight applications (tampons of Glyco-Thymoline (Kress). The stenosis is gradually growing less and the tissues of the os are becoming less rigid.

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